# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

9433 — 09405 Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 3 may be removed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. **PLACE OF DEATH** — a. COUNTY: Prince George's — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville, Md
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 4003 Longfellow Street

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Pro George's
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville, Md.
   d. STREET ADDRESS: 4003 Longfellow Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Irene — Middle: Edith — Last: Akers

4. **DATE OF DEATH**: Month: August — Day: 28, — Year: 19 60

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 13, 1904

9. AGE (In years lost birthday): 56 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Washington D. C.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Fred Day

14. MOTHER'S MAIDEN NAME: Mary Bnuseke

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

INFORMANT — Address: John H Akers Hyattsville, Md.

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Sarcoma of Urinary Bladder — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): & Generalized Metastasis.
DUE TO (c):

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

1991

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I attended the deceased from June 4, 1960, to Aug 28, 1960, that I last saw the deceased alive on Aug 25, 19 60, and that death occurred at M, from the causes and on the date stated above.

ACTUAL SIGNATURE: A. Deitz M.D. — ADDRESS (Street, city or town, state): 4314 GALLATIN ST. — DATE SIGNED

PHYSICIAN'S NAME (Type): AARON DEITZ, M.D. — HYATTSVILLE, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Sept 1, 1960

22c. NAME OF CEMETERY OR CREMATORY: Arlington National

22d. LOCATION (City, town, or county) (State): Arlington Virginia

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: F. Gasch's Sons Hyattsville, Md.

24a. REC'D BY REGISTRAR DATE: SEP 1 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

VS A15 (4)
15M 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9448 Items 6,9,10 Film 269 8-19-60 et

09406

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Beverly
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince George General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Woodlawn
d. STREET ADDRESS: 4720 68th Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: Henry — Last: Albright Sr.

4. DATE OF DEATH: Month: Aug. — Day: 2 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 19, 1837 (1875)

9. AGE (In years last birthday): 87 (85) yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Railway Clerk

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY?: Us A

13. FATHER'S NAME: Henry A Albright

14. MOTHER'S MAIDEN NAME: Nargaret Ferrell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): nO

16. SOCIAL SECURITY NO.: 719-09-7215

17. INFORMANT: Anna Belle Albright — Address: Woodlawn Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 hr
DUE TO (b): Hypertension, Heart Disease — 15 yrs
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from 2-12-60, 19__, to 8-2, 1960 that (I) ~~(we)~~ last saw the deceased alive on 8-2, 1960, and that death occurred at 2P. M. from the causes and on the date stated above.

22a. SIGNATURE: John P. Clum M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): John P. Clum

22d. ADDRESS: Hyattsville Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: Aug 4, 1960

23c. NAME OF CEMETERY OR CREMATORY: Ft Lincoln Crematory

23d. LOCATION (City, town, or county) (State): Colmar Manro Md.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: F. Gasch's Sons Hyattsville, Md.

25a. REC'D BY REGISTRAR DATE: AUG 8 '60

25b. REGISTRAR'S SIGNATURE: Clifton L. Krauss

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

John F. Clum

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9443 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 09407

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

**1. PLACE OF DEATH**
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Tokoma Park
c. LENGTH OF STAY IN 1b: 40 Yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): 428 Ethan Allen Avenue

**2. USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Tokoma Park
d. STREET ADDRESS: 428 Ethan Allen Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First James — Middle Elwood — Last Ashford

**4. DATE OF DEATH**: Month August — Day 30, — Year 19 60

**5. SEX**: Male

**6. COLOR OR RACE**: White

**7.** MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

**8. DATE OF BIRTH**: Nov. 26, 1900

**9. AGE** (In years last birthday): 59 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Electrician

**10b. KIND OF BUSINESS OR INDUSTRY**: Construction

**11. BIRTHPLACE** (State or foreign country): Washington D. C.

**12. CITIZEN OF WHAT COUNTRY?**: U. S. A.

**13. FATHER'S NAME**: Joseph Franklin Ashford

**14. MOTHER'S MAIDEN NAME**: Georganna Grimes

**15. WAS DECEASED EVER IN U. S. ARMED FORCES?** (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW 11

**16. SOCIAL SECURITY NO.**:

**17. INFORMANT**: Charles R. Ashford — Address: Same as #2

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Broncho Pneumonia — 2 wks
DUE TO (b): Bronchogenic Ca Lung — 1 mo
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

162.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

MEDICAL CERTIFICATION

**20a. EXTERNAL CAUSE WAS** PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

**20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour o. m. p. m. — Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not while at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Dayton O Watkins M.D.

EXAMINER'S NAME (Type): DAYTON O WATKINS

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

**22a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**22b. DATE THEREOF**: 9/2/60

**22c. NAME OF CEMETERY OR CREMATORY**: Arlington National

**22d. LOCATION** (City, town, or county) (State): Arlington, Va.

**23. FUNERAL DIRECTOR'S SIGNATURE**: F. Gasch's Sons — ADDRESS: Hyattsville, Md.

**24a. REC'D BY REGISTRAR** DATE SEP 6 '60

**24b. REGISTRAR'S SIGNATURE**: Arthur S. Krauss

1

FOR STATE HEALTH DEPT.

M

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9449

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09408

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1. PLACE OF DEATH
   a. COUNTY: Prince George's — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cheverly
   c. LENGTH OF STAY IN 1b: 4 hours
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Prince George's
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): College Park
   d. STREET ADDRESS: 9722 Wichita Avenue
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: George — Middle: Curtis — Last: Atkins

4. DATE OF DEATH: Month: August — Day: 14 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 27, 1919

9. AGE (In years last birthday): 41 yrs. — IF UNDER 1 YEAR: Months 4, Days 18 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist

10b. KIND OF BUSINESS OR INDUSTRY: Electronics

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Curtis W. Atkins

14. MOTHER'S MAIDEN NAME: Ici V. Webster

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes (If yes give war or dates of service): WW II

16. SOCIAL SECURITY NO.: 224-03-8647

17. INFORMANT — Address: Mrs Naomi Atkins, Same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hemorrhage and shock
DUE TO (b): Rupture of the liver
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): XXXXXXXXXXXXXXXXXXXXXXXX

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cirrhosis of the liver

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Driver of an automobile that ran into another car

20c. TIME OF INJURY: Hour: XX a.m. 8:20 p.m. — Month, Day, Year: 8/13/60

20d. INJURY OCCURRED: While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Street

20f. (City or town) (County) (State): College Park P.G. Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE: James I. Boyd M.D.

EXAMINER'S NAME (Type): James I. Boyd

Address (Street, city, town, or county):

DATE SIGNED: 8/14/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug. 16, 1960
22c. NAME OF CEMETERY OR CREMATORY: Dayton Cemetery
22d. LOCATION (City, town, or country) (State): Dayton, Virginia.

23. FUNERAL DIRECTOR: LINDSEY & SONS Partner — ADDRESS: 473 S. Main St. Harrisonburg, Va.

24a. REC'D BY REGISTRAR DATE: AUG 16 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9524 — Reg. Dist. No. 09409

**1. PLACE OF DEATH**
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cap Pines
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): 6014-67 Place

**2. USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prin Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 11 East Pines
d. STREET ADDRESS: 6014-67th Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

**3. NAME OF DECEASED** (Type or print): First: Mabel — Middle: Enough — Last: Bane

**4. DATE OF DEATH**: Month: Aug — Day: 6 — Year: 1960

**5. SEX**: Female

**6. COLOR OR RACE**: White

**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☑ **DIVORCED** ☐

**8. DATE OF BIRTH**: June 10, 1886

**9. AGE** (In years last birthday): 74 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Clerk

**10b. KIND OF BUSINESS OR INDUSTRY**: Retired

**11. BIRTHPLACE** (State or foreign country): New York

**12. CITIZEN OF WHAT COUNTRY?**: U. S. A.

**13. FATHER'S NAME**: Hebron E. Burton

**14. MOTHER'S MAIDEN NAME**: Amelia Cady

**15. WAS DECEASED EVER IN U. S. ARMED FORCES?** (Yes, no, or unknown): No — (If yes, give war or dates of service)

**16. SOCIAL SECURITY NO.**:

**17. INFORMANT**: Address: Forest Fletcher, same as #2

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Cardiovascular renal disease
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4427

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☑

**20a. EXTERNAL CAUSE WAS** PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

**20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour: o. m. / p. m. — Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not while at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and find that death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: James I. Boyd M.D.
EXAMINER'S NAME (Type): James I. Boyd
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
DATE SIGNED: Aug 6, 1960

**22a. BURIAL, CREMATION, REMOVAL** (Specify): Burial — **22b. DATE THEREOF**: 8-9-60 — **22c. NAME OF CEMETERY OR CREMATORY**: Cedar Hill — **22d. LOCATION** (City, town, or county) (State): Suitland Md.

**23. FUNERAL DIRECTOR'S SIGNATURE** — **ADDRESS**: Lee Funeral Home. Washington D.C.

**24a. REC'D BY REGISTRAR** DATE: AUG 9 '60

**24b. REGISTRAR'S SIGNATURE**: Arthur L. Thrasher

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

09410

# CERTIFICATE OF DEATH

9450 Item 16 Filed 8-11-60 eb

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 12 Da.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince Georgeas General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chapal Oaks Md.
d. STREET ADDRESS: 5707 Addison Rd. N.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: John; Middle: ; Last: Barksdale

4. DATE OF DEATH: Month: Aug.; Day: 3; Year: 19 60

5. SEX: Male

6. COLOR OR RACE: C.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6-15-06

9. AGE (In years last birthday): 54 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Checker

10b. KIND OF BUSINESS OR INDUSTRY: Lumber

11. BIRTHPLACE (State or foreign country): Canton S.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Tom Barksdale

14. MOTHER'S MAIDEN NAME: Lora Rhafel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 578-05-9313

17. INFORMANT: Lois Barksdale — Address: 5707 Addison Rd. N.E.

## MEDICAL CERTIFICATION

1B. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic bronchogenic carcinoma
DUE TO
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH

162.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐ X

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Port II of item 1B.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from June 1960 to Aug 3 1960 that (I) (~~we~~) last saw the deceased alive on Aug 3 1960 and that death occurred at 8:00pm from the causes and on the date stated above.

22a. SIGNATURE: Harry N. Carlton, M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Aug 3, 1960

22c. PHYSICIAN'S NAME (Type): Dr. H. N. Carlton

22d. ADDRESS: 940-25th St., N.W. Wash 7, D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8-6-60
23c. NAME OF CEMETERY OR CREMATORY: Harmony Memorial Park
23d. LOCATION (City, town, or county) (State): 7601 Shiff Rd. Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Thomson Fun Servs
ADDRESS: 904-6 St NW
25a. REC'D BY REGISTRAR DATE: AUG 8 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 22,23 FilmG269 8-19-60 et

9525

## CERTIFICATE OF DEATH

09411 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural — Bowie
c. LENGTH OF STAY IN 1b: 50 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: —

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Prince Geo
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural — Bowie
d. STREET ADDRESS: —
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First James Middle Pete Last Barnes

4. DATE OF DEATH: Month Aug Day 16, Year 1960

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: April 22 1883
9. AGE (In years last birthday) 77 yrs.
IF UNDER 1 YEAR: Months — Days —
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 218-03-9262
INFORMANT: Rachel Barnes Address: Bowie Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure — Interval between onset and death: 1 wk
DUE TO (b): Hypertension — 5 yrs
DUE TO (c): Arteriosclerosis
444X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1955, to Aug 16, 1960, that I last saw the deceased alive on Aug 16, 1960, and that death occurred at 3:10 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Dr Henry A. Wise M.D.
ADDRESS (Street, city or town, state): 149 9th St Bowie
DATE SIGNED: 8/16/60
PHYSICIAN'S NAME (Type): Henry A. Wise Jr Bowie, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-19-60
22c. NAME OF CEMETERY OR CREMATORY: Pleasant Grove Cem.
22d. LOCATION (City, town, or county) (State): Bowie, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Johnson's Mortuary, 34 Lafayette Ave., Annapolis Md.
24a. REC'D BY REGISTRAR DATE: AUG 18 '60
24b. REGISTRAR'S SIGNATURE: Clifton L. Krauss

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9451 — 09412

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 78 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 4205 Oglethorpe St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mildred — Middle: Q. — Last: Barton

4. DATE OF DEATH: Month: August — Day: 3rd — Year: 1960

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 25 1918

9. AGE (In years last birthday): 41 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Telephone Operator

10b. KIND OF BUSINESS OR INDUSTRY: Answering service

11. BIRTHPLACE (State or foreign country): Luenburg Co, Va.

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: James W. Vaughan

14. MOTHER'S MAIDEN NAME: Lois Sheffield

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 230-18-6331

17. INFORMANT: Lois Vaughan, mother — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Adeno carcinoma of the Ascend Colon
DUE TO (c):

153.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5/17 1960 to 8/3 1960 that (I) (we) last saw the deceased alive on 8/3 1960, and that death occurred at 11.17 M, from the causes and on the date stated above.

22a. SIGNATURE: F. Flores M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): F. FLORES

22d. ADDRESS: PRINCE GEORGE'S HOSPITAL

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/6/60

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill

23d. LOCATION (City, town, or county) (State): Suitland Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Kelley's Funeral Home Inc.

ADDRESS: Mt. Rainier, Md.

25a. REC'D BY REGISTRAR DATE: AUG 9 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be [illegible] by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9526 — 09413 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clinton
c. LENGTH OF STAY IN 1b: 4 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 56 Horse Shoe Drive

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clinton
d. STREET ADDRESS: 156 Horse Shoe Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: Henry — Last: Batton

4. DATE OF DEATH: Month: Aug — Day: 3 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 24, 1918

9. AGE (In years last birthday): 42 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman

10b. KIND OF BUSINESS OR INDUSTRY: Meat Product

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Henry Batton

14. MOTHER'S MAIDEN NAME: Bobbie Murphy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW II

16. SOCIAL SECURITY NO.: 579-07-617

17. INFORMANT: Mrs Edith Batton, same as #7 — Address

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hemorrhage and Shock — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Gun shot wound of head
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 976 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Shot self in head with a 22 Cal. rifle

20c. TIME OF INJURY: Hour 7 ☐ a.m. ☐ p.m. — Month, Day, Year: 8-3 1960

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) Clinton (County) PG (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: James L. Boyd M.D.
EXAMINER'S NAME (Type): James L. Boyd
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: Aug 3, 1960

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-6-60
22c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln
22d. LOCATION (City, town, or county) (State): Bladensburg, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Lee Funeral Home – Washington D.C.

24a. REC'D BY REGISTRAR — DATE: AUG 5 '60

24b. REGISTRAR'S SIGNATURE: Carlton L. Timms

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9527

## CERTIFICATE OF DEATH

09414
Reg. Dist. No.

1

M

X

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82

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hillcrest Heights
c. LENGTH OF STAY IN 1b: 4 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 2210 Dameson St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hillcrest Heights
d. STREET ADDRESS: 2210 Dameson St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Regina — Middle: M. — Last: Beck

4. DATE OF DEATH: Month: Aug — Day: 10 — Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: March 19, 1882

9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Domestic

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Francis Guth

14. MOTHER'S MAIDEN NAME: Louise Hentchel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: ?

INFORMANT: Frank Guth — Address: 2210 Dameson St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia
DUE TO (b): Hypertensive Arteriosclerotic Cardiovascular Renal
DUE TO (c):

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/—, 1958, to 8/11, 1960, that I last saw the deceased alive on 8/10, 1960, and that death occurred at 1:15 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: David Lenarduzzi M.D.
ADDRESS (Street, city or town, state): 2901 Fairlawn St SE
DATE SIGNED: 8/11/60

PHYSICIAN'S NAME (Type): David Lenarduzzi — Wash. 11, D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-13-60
22c. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
22d. LOCATION (City, town, or county) (State): Baltimore Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Geo. L. Schwab Funeral Home
ADDRESS: Francis D. Miller 2101 Frederick Rd. Balto. Md.

24a. REC'D BY REGISTRAR DATE: AUG 15 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be [illegible] by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/SB

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FOR STATE HEALTH DEPT.

M

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 9452 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09415

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1. PLACE OF DEATH
   a. COUNTY: Prince George's — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cheverly
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institutional, Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Prince George's
   c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Upper Marlboro
   d. STREET ADDRESS: Box 2085
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Earl Mathew — Middle: Belt — Last:

4. DATE OF DEATH: Month: August — Day: 13 — Year: 19 60

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 1 -18 -43

9. AGE (In years last birthday): 17 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Samuel Belt

14. MOTHER'S MAIDEN NAME: Susie(Belt) Sellmen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Annette Belt Box 2085 Upper Marlboro, M

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hemorrhage and shock — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO (b): Severance of the Iliac Artery - XXXX right

Conditions, if any, which gave rise to immediate ceuse (a), stating the underlying cause lest. DUE TO (c): Gun shot wound of the abdomen

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Shot during an altercation

20c. TIME OF INJURY — Hour: 5:30 a.m. [XX] p.m. [ ] — Month, Day, Yeer: Aug.13/60

20d. INJURY OCCURRED While at work [ ] Not While at work [X]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Sunset Inn

20f. (City or town) (County) (State): Upper Marlboro P. G. Md

21. I certify that I took charge of the remains described above, held an Autopsy [X] Inspection [X] Inquiry [X] and in my opinion death resulted from: Natural causes [ ] Accident [ ] Suicide [ ] Homicide [X] Undetermined manner [ ]

ACTUAL SIGNATURE: James I. Boyd M.D.

EXAMINER'S NAME (Type): James I. Boyd

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

Address (Street, city, town, or county):

DATE SIGNED: 8/14/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-16-60

22c. NAME OF CEMETERY OR CREMATORY: Mt. Carmel

22d. LOCATION (City, town, or country) (State): Upper Marlboro, Md.

23. FUNERAL DIRECTOR — ADDRESS: Myrtle K. Rollins 4339 Hunt Pl., N.E, D.C.

24a. REC'D BY REGISTRAR — DATE: AUG 16 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

(M)

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9453

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
## CERTIFICATE OF DEATH

09416

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 5 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
STATE: Maryland — COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Landover
d. STREET ADDRESS: 6430 Old Landover Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Sadie — Middle: R — Last: Bickley
4. DATE OF DEATH: Month: Aug. — Day: 13 — Year: 1960
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Mar. 7, 1877
9. AGE (In years last birthday): 83 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: own Home
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: Franz Rankin
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: George Bickley — Address: Landover Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Heart Disease — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Coronary Insufficiency
DUE TO (c):
420.00

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic Cholecystitis. — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I ar Port II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Hame, farm, factary, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this haspital) attended the deceased from Jan 2, 19 60 to Aug. 15, 19 60, that (I) (we) last saw the deceased alive an ____ 19 60, and that death accurred at 11:40 A.M., from the causes and an the date stated abave.

22a. SIGNATURE: A Deitz — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 8-15-60
22c. PHYSICIAN'S NAME (Type): A Deitz
22d. ADDRESS: Hyattsville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 8/18/60 — 23c. NAME OF CEMETERY OR CREMATORY: Ft Lincoln Cemetery — 23d. LOCATION (City, town, or county) (State): Colmar Manor Md.
24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: F. Gasch's Sons Hyattsville Md.
25a. REC'D BY REGISTRAR — DATE: AUG 19 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9528

## CERTIFICATE OF DEATH

09417

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North Englewood
c. LENGTH OF STAY IN 1b: 64 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Dignes Rest Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Geo.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North Englewood
d. STREET ADDRESS: 6003 Reed St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Cora — Middle: L. — Last: Borders

4. DATE OF DEATH: Month: Aug. — Day: 29 — Year: 1960

5. SEX: F

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: April 30, 1877

9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Marion, N.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Crisp

14. MOTHER'S MAIDEN NAME: Arie Carson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT — Address: James W. Crisp - 6003 Reed St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Arteriosclerosis
DUE TO (c):

3347

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Natural Conditions & age-and Heat -

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I attended the deceased from 1-7-, 1960, to 8-29-, 1960 that I last saw the deceased alive on 8-29-, 1960, and that death occurred at 4:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John W. Robinson, M.D. — ADDRESS (Street, city or town, state): 1001 Eastern Ave NE, — DATE SIGNED: 8/29/60

PHYSICIAN'S NAME (Type): John W. Robinson M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 8-30-60

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or county) (State): MARION N.C.

23. FUNERAL DIRECTOR'S SIGNATURE: Henry L Washington & Sons — ADDRESS: 4925 Deane Ave

24a. REC'D BY REGISTRAR — DATE: SEP 1 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/SB

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9454

09418

1

M

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
1SM 9/59

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 2 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince George General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt. Rainier
d. STREET ADDRESS: 3210 Perry Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: John — Middle: T — Last: Bostick

4. DATE OF DEATH: Month: Aug. — Day: 4 — Year: 19 60

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: Nov. 5 - 1905

9. AGE (In years last birthday): 54 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Thomas Bostick

14. MOTHER'S MAIDEN NAME: [illegible]r Mary Brewer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchiogenic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 8 mos
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
162.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug. 2 19 60 to Aug. 4 19 60 that (I) (we) last saw the deceased alive on Aug. 4 19 60 and that death occurred at 5:10 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Thomas J Maloney M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STATE PHYS. ☒ — 22b. DATE SIGNED: 4 Aug 60.

22c. PHYSICIAN'S NAME (Type): THOMAS J. MALONEY

22d. ADDRESS: 2205 - Cheverly Ave. Cheverly, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug. 5th-60

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

23d. LOCATION (City, town, or county) (State): Suitland, Maryland.

24. FUNERAL DIRECTOR'S SIGNATURE: Simmons Bros — ADDRESS: 660 Good Hope Rd. Wash. D.C.

25a. REC'D BY REGISTRAR: DATE AUG 8 '60

25b. REGISTRAR'S SIGNATURE: Caitlyn S. Kraus

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

# CERTIFICATE OF DEATH

9455 09419

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 16 Hr
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince George General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Ann Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis Junction
d. STREET ADDRESS: 02x-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Helen — Middle: M — Last: Boswell

4. DATE OF DEATH: Month: Aug. — Day: 25 — Year: 19 60

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 7, 1889

9. AGE (In years last birthday): 71 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Centerville, Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel Clark Allen

14. MOTHER'S MAIDEN NAME: Mary K Reeves

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Jane Mitten — Address: Annapolis Junction Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Glomerulo Nephritis — INTERVAL BETWEEN ONSET AND DEATH: 2 d.
DUE TO (b): Cellulitis of st leg — 4 d.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

692.4

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug 20 1960, to Aug 25 1960, that (I) (we) last saw the deceased alive on Aug 25 1960, and that death occurred at 6 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Robert S McCeney M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Robert S. McCeney MD.

22d. ADDRESS: 402 Main St Laurel, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug 27, 1960

23c. NAME OF CEMETERY OR CREMATORY: Lorraine Park Cem

23d. LOCATION (City, town, or county) (State): Baltimore Md

24. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: DeWitt Donaldson, Laurel, Md.

25a. REC'D BY REGISTRAR DATE: AUG 30 '60

25b. REGISTRAR'S SIGNATURE: Arthur L. Krause

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospitol or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9508 **CERTIFICATE OF DEATH** 09420

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel, Md.
c. LENGTH OF STAY IN 1b 4 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Laurel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Pro George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) High Bridge, Md.
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print) First James Middle Samuel Last Brady sr

4. DATE OF DEATH Month August Day 4, Year 1960

5. SEX male

6. COLOR OR RACE white

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH Sept 15, 1890

9. AGE (In years last birthday) 69 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck

10b. KIND OF BUSINESS OR INDUSTRY Farmer

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME John A Brady

14. MOTHER'S MAIDEN NAME Rosella Henry

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address Gertrude S Brady High Bridge Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | Acute enterocolitis | 4 days |
| DUE TO (b) | Peritonitis | 1 day |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) | Perforated Diverticulitis | 1 day |

572.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

Acute Cystitis - Gen -

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/1, 1960, to 8/4, 1960, that I last saw the deceased alive on 8/4, 1960, and that death occurred at 4.30 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE B P Warren M.D. ADDRESS (Street, city or town, state) Laurel Md DATE SIGNED 8/4/60

PHYSICIAN'S NAME (Type) B. P. Warren Laurel, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF Aug 6, 1960

22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery

22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS F. Gasch's Sons Hyattsville, Maryland.

24a. REC'D BY REGISTRAR DATE AUG 8 '60

24b. REGISTRAR'S SIGNATURE Arthur L. Harris

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 3, Film G-273 10/21/60.cac

9529 **CERTIFICATE OF DEATH** 09421

Reg. Dist. No.

1

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1. **PLACE OF DEATH**
a. COUNTY: PRINCE GEORGES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANDREWS AIR FORCE BASE
c. LENGTH OF STAY IN 1b: 1 DAY
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: USAF HOSP ANDREWS, WASH 25, DC

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: DISTRICT OF COLUMBIA — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON
d. STREET ADDRESS: 1222 U Street SE, Apt 3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

47 X-3

3. **NAME OF DECEASED** (Type or print): First DEREK — Middle NEWBORN JUSTIN — Last BRAKE

4. **DATE OF DEATH**: Month AUGUST — Day 18 — Year 19 60

5. SEX: MALE

6. COLOR OR RACE: CAUCASIAN

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 17 AUGUST 1960

9. AGE (In years last birthday) yrs. — IF UNDER 1 YEAR: Months — Days 1 — IF UNDER 24 HRS.: Hours 2 — Min. 50

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: UNITED STATES

13. FATHER'S NAME: DEWEY LEE BRAKE

14. MOTHER'S MAIDEN NAME: ROBERTA ANN OYLER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service): N/A

16. SOCIAL SECURITY NO.: NONE

INFORMANT: PATIENT'S CHART — Address

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): RESPIRATORY DISTRESS — INTERVAL BETWEEN ONSET AND DEATH: 25 HOURS
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO (c):

773X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 17 AUGUST, 19 60, to 18 AUGUST, 19 60 that I last saw the deceased alive on 18 AUGUST, 19 60, and that death occurred at 1:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John A Moore M.D. — ADDRESS (Street, city or town, state): ANDREWS AIR FORCE BASE — DATE SIGNED: 18 AUG 60

PHYSICIAN'S NAME (Type): JOHN A MOORE, MAJ USAF (MC) — USAF HOSPITAL ANDREWS, WASHINGTON 25, D C

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 8-19-60

22c. NAME OF CEMETERY OR CREMATORY: Morgue

22d. LOCATION (City, town, or county) (State): Washington D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: Note from: Andrews A.F.B. — ADDRESS

24a. REC'D BY REGISTRAR DATE: AUG 23 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

Ross

2050963XVEA5

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

09422

M 9530

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Beltsville
c. LENGTH OF STAY IN 1b: 20yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 11418 Cherry Hill Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 74 Beltsville
d. STREET ADDRESS: 11418 Cherry Hill Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HARRY Middle L. Last BRIGGS, JR
4. DATE OF DEATH: Month Aug. Day 11, Year 1960
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 7, 1882
9. AGE (In years, last birthday): 78 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Asst. Industrial Education
10b. KIND OF BUSINESS OR INDUSTRY: U of Md. (Ret.)
11. BIRTHPLACE (State or foreign country): Philadelphia Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Harry L. Briggs
14. MOTHER'S MAIDEN NAME: Elizabeth ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Mary A. Briggs. Address: (Same as #2)

I

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Bronchopneumonia | 3d |
| DUE TO (b) | Chronic Emphysema | 5 yrs |
| DUE TO (c) | A.S.C.V. disease | 10 yrs |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3/27 1960 to 8/11 1960 that (I) (we) last saw the deceased alive on 8/9 1960 and that death occurred at 7:45 M, from the causes and on the date stated above.

22a. SIGNATURE: J. M. Warren — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8/11/60
22c. PHYSICIAN'S NAME (Type): J. M. WARREN
22d. ADDRESS: Laurel, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Aug 13, 1960
23c. NAME OF CEMETERY OR CREMATORY: George Washington Cemetery
23d. LOCATION (City, town, or county) (State): Prince George County Md

24. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: J. Arthur Walters, 254 Carroll St NW DC
25a. REC'D BY REGISTRAR DATE: AUG 15 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9444

09423

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 2+ years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 7219 Minter Place

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): S4 Takoma Park
d. STREET ADDRESS: 7219 Minter Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First BESSIE — Middle — Last BRITT

4. DATE OF DEATH: Month AUG — Day 7 — Year 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: Aug. 23, 1880
9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Homemaker
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): New York State
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Golder
14. MOTHER'S MAIDEN NAME: Not Available

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Harold B. Colvin Address: (same as #2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hypertensive Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: old
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
4423

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6 May 1953 to 7 Aug 1960 that (I) (we) last saw the deceased alive on 6 Aug 1960, and that death occurred at 5:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Ernest A. Sarao M.D.
ATTENDING PHYS. X MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 7 Aug 60
22c. PHYSICIAN'S NAME (Type): ERNEST A. SARAO
22d. ADDRESS: 7006 New Hampshire Ave. S.P. Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Aug 10, 1960
23c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
23d. LOCATION (City, town, or county) (State): Washington DC

24. FUNERAL DIRECTOR'S SIGNATURE: J. Arthur Walters ADDRESS: 254 Carroll St. N.W. DC
25a. REC'D BY REGISTRAR DATE: AUG 9 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

1

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9456

09424

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 1½ hr
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince George General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): N. Englewood
d. STREET ADDRESS: 6010 Pratt St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

M

077

3. NAME OF DECEASED (Type or print): First: Cora; Middle: ; Last: Brooks

4. DATE OF DEATH: Month: Aug. Day: 4 Year: 1960

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 8, 1895

9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): St. Mary's Co. Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Thomas

14. MOTHER'S MAIDEN NAME: Cecelia Dyson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 8 hours
DUE TO
331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug. 3 1960, to Aug. 4 1960, that (I) (we) last saw the deceased alive on Aug. 4 1960, and that death occurred at 3A.M. from the causes and on the date stated above.

22a. SIGNATURE: Thomas J Maloney M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 4 Aug 60

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/9/60

23c. NAME OF CEMETERY OR CREMATORY: Arlington National

23d. LOCATION (City, town, or county) (State): Arlington, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: John L. Bennett ADDRESS: 30 H Street, N.E. D.C.

25a. REC'D BY REGISTRAR DATE: AUG 8 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9509 09425

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
c. LENGTH OF STAY IN 1b: 24 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 122 Lafayette Avenue

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Pr. Geo.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
d. STREET ADDRESS: 122 Lafayette Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Hollis — Middle: Teel — Last: Brown

4. DATE OF DEATH: Month: 8 — Day: 24 — Year: 1960

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 23, 1893

9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): realtor

10b. KIND OF BUSINESS OR INDUSTRY: self-employed

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Peter Brown

14. MOTHER'S MAIDEN NAME: Ida Josephine Teel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Jane B. Barham — Address: Laurel, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Myocardial infarction | 1 min. |
| DUE TO (b) | Atherosclerosis | 10 yr. |
| DUE TO (c) | | |

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 1956 to Aug 1960 that (I) (~~me~~) last saw the deceased alive on 8/24 1960 and that death occurred at 1 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Frank L. Weaver Jr. M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/25/60

22c. PHYSICIAN'S NAME (Type): FRANK L. WEAVER JR.

22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/27/60

23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cem.

23d. LOCATION (City, town, or county) (State): Colmar Manor, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: DeWitt Davidson

ADDRESS: Laurel, Md

25a. REC'D BY REGISTRAR DATE: AUG 30 '60

25b. REGISTRAR'S SIGNATURE: Clothier L. Hunt

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9531

## CERTIFICATE OF DEATH

09426
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Southern Md. Hospital Center

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Virginia — b. COUNTY Gloucester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ischley P.O.
d. STREET ADDRESS 83X-3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First LUCY — Middle Woodland — Last BROWN

4. DATE OF DEATH: Month 8 — Day 7 — Year 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov. 14 1873
9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home Owner
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Jeff Woodland
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
INFORMANT: MRS Edna Hayes — Address: R.D. Box 1203 Upper Marlboro, Md.

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): CARDIOVASCULAR DISEASE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.1
DUE TO (c): ARTERIOSCLEROSIS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)
20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from _____, 19____, to 8-7, 1960, that I last saw the deceased alive on _____, 19____, and that death occurred at 8:52 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Alfred R Lapin M.D. — ADDRESS (Street, city or town, state): Clinton, Md. — DATE SIGNED
PHYSICIAN'S NAME (Type): ALFRED R. LAPIN, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-9-60
22c. NAME OF CEMETERY OR CREMATORY: Singleton
22d. LOCATION (City, town, or county) (State): Gloucester, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Latane Bros - Upper Marlboro Md — ADDRESS

24a. REC'D BY REGISTRAR DATE: AUG 9 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Mann

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# 9457 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09427
Reg. Dist. No.

1

M

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHEVERLY
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Geo General

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Md
b. COUNTY: Pr Geo
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): aquasco X
d. STREET ADDRESS: no / unknown
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

099

3. NAME OF DECEASED (Type or print): First SHILEY — Middle ANN — Last BROWN

4. DATE OF DEATH: Month 8 — Day 24 — Year 1960

5. SEX: F

6. COLOR OR RACE: C

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: DEC. 23 1959

9. AGE (In years last birthday): 8 months

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min. 2

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): aquasco md

12. CITIZEN OF WHAT COUNTRY? USA

1

13. FATHER'S NAME: GEORGE NELSON Brown

14. MOTHER'S MAIDEN NAME: Myrtle Davis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: no

17. INFORMANT: George N Brown — Address: aquasco md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypoadrenalism — INTERVAL BETWEEN ONSET AND DEATH: 2

525 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Interstitial Pneumonia — 2 week
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. no

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) no

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year: no 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Dayton O Watkins, M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 8-25 60

EXAMINER'S NAME (Type): DAYTON O WATKINS

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 8-25-60

22c. NAME OF CEMETERY OR CREMATORY: John Wesley

22d. LOCATION (City, town, or county) (State): Aquasco, Md.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: The Hunter Funeral Home, Waldorf, Md.

24a. REC'D BY REGISTRAR DATE: AUG 30 '60

24b. REGISTRAR'S SIGNATURE: Clifton S. Evans

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9512

09428

## CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

**1. PLACE OF DEATH**
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale
c. LENGTH OF STAY IN 1b: 13 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Iceland Memorial

**2. USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Geo
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 65 E. Riverdale
d. STREET ADDRESS: 5600 Nicholson St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Perry Middle: W. Last: Browning

**4. DATE OF DEATH**: Month: Aug. Day: 28 Year: 1960

**5. SEX**: male

**6. COLOR OR RACE**: White

**7.** MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

**8. DATE OF BIRTH**: 10-16-78

**9. AGE** (In years last birthday): 81 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Retired

**10b. KIND OF BUSINESS OR INDUSTRY**: Coffee Merchant

**11. BIRTHPLACE** (State or foreign country): Maryland

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Theodore F. Browning

**14. MOTHER'S MAIDEN NAME**: Ella Maddox

**15. WAS DECEASED EVER IN U. S. ARMED FORCES?** (Yes, no, or unknown) (If yes, give war or dates of service): No

**16. SOCIAL SECURITY NO.**:

**17. INFORMANT** Address: Hospital Record

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Acute Coronary Thrombosis | 4 hrs |
| DUE TO | arterio sclerotic Heart Dis | 1 day |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) | General arteriosclerosis | unknown |
| DUE TO (c) | | |

420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes Mellitus

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a.** ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Month, Day, Year: Hour o. m. / p. m. — 19

**20d. INJURY OCCURRED** While at work ☐ Not while at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from aug 16, 1960, to aug 28, 1960, that (I) (we) last saw the deceased alive on aug 28 1960 and that death occurred at 6½ P.M., from the causes and on the date stated above.

**22a. SIGNATURE**: L W Melin M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED**: 8-28-60

**22c. PHYSICIAN'S NAME** (Type): L W Melin MD

**22d. ADDRESS**: Riverdale Md

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF**: 9/1/60

**23c. NAME OF CEMETERY OR CREMATORY**: Congressional

**23d. LOCATION** (City, town, or county) (State): Washington D. C.

**24. FUNERAL DIRECTOR'S SIGNATURE** ADDRESS: F. Gasch's Sons — Hyattsville, Md.

**25a. REC'D BY REGISTRAR** DATE: AUG 31 '60

**25b. REGISTRAR'S SIGNATURE**: Arthur L. Harris

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9532

## CERTIFICATE OF DEATH

09429 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): T.B. Brandywine
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Brandywine-Waldorf, Med. Clinic
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brandywine

3. NAME OF DECEASED (Type or print): First: Joseph Middle: Anthony Last: Burton

4. DATE OF DEATH: Month: August Day: 2 Year: 1960

5. SEX: M.

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 18, 1898

9. AGE (If years last birthday): 62 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chemist

10b. KIND OF BUSINESS OR INDUSTRY: Dairy

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Lee Burton

14. MOTHER'S MAIDEN NAME: Mary Thurston

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW#1

16. SOCIAL SECURITY NO.: 223-18-5707

INFORMANT: Mrs. Jane M. Burton, Address: Brandywine Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 6 hr
DUE TO (b): Hemolytic Coronary Vascular Renal Atherosclerosis — years
DUE TO (c): Age Process

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6-10, 19 55 to 8-2, 1960, that I last saw the deceased alive on 8-2, 19 60, and that death occurred at 7:45 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Richard Dobson M.D. — ADDRESS (Street, city or town, state): Brandywine md — DATE SIGNED:

PHYSICIAN'S NAME (Type): Rear Adm H. Dobson — Brandywine MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug. 5, 1960
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Hunter Funeral Home, Waldorf, Md.

24a. REC'D BY REGISTRAR DATE: AUG 10 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

Burial Req. 5/1/60 Arlington National Arlington, Virginia
Nurse Funeral Home Waldorf, Md.

Prince George Mary Land Prince George
T.B. Brandywine Brandywine
Brandywine-Waldorf, Med. Clinic
x
Ethony
M. White April 19 1893 6.2 Newest 23 60
Chemist Dairy Virginia U.S.A
Robert Lee Burton Mary Thurston Brandywine Md.
Yes NW#1 223813-5707 Mrs. Jane M. Burton,

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9458 — 09430

1

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1. PLACE OF DEATH
a. COUNTY: P rince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 3 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 48 Mt. Rainier
d. STREET ADDRESS: 4211 28th Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Walter — Middle: T — Last: Cade

4. DATE OF DEATH: Month: Aug. — Day: 11 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 22 Mar 1881

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): COOK

10b. KIND OF BUSINESS OR INDUSTRY: C+O R.R.

11. BIRTHPLACE (State or foreign country): VIRGINIA

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs Ethel L. Buff — Address: 42H 28 St. Mt Rainier, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebrovascular Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b): Cerebrovascular Arteriosclerosis

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. 331 X

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Aug. 8 1960 to Aug. 11 1960 that (I) (we) last saw the deceased alive on Aug. 11 1960 and that death occurred at 5.45 AM from the causes and on the date stated above.

22a. SIGNATURE: William D Rossin M.D., M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Aug 11, 1960

22c. PHYSICIAN'S NAME (Type): Dr. Willian D. Rossin, M.D.

22d. ADDRESS: 5304 ANNAPOLIS RD, Bladensburg MD,

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug 13, 1960

23c. NAME OF CEMETERY OR CREMATORY: H. Lincoln Cemetery

23d. LOCATION (City, town, or county) (State): Bladensburg Md

24. FUNERAL DIRECTOR'S SIGNATURE: W.W. Chambers Co.

ADDRESS: Riverdale, Md 5201 Cleveland Ave

25a. REC'D BY REGISTRAR DATE: AUG 18 '60

25b. REGISTRAR'S SIGNATURE: Cletus E. Kraus

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

9533 Reg. Dist. No. 09431

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGES MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CLINTON
c. LENGTH OF STAY IN 1b: 32 YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: RT 2 BOX 6

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: PRINCE GEORGES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CLINTON md
d. STREET ADDRESS: RT 2 BOX 6
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First LOLITA Middle CARLYN. Last CARRICO
4. DATE OF DEATH: Month AUG. Day 16 Year 1960
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan 11 1904
9. AGE (In years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: ___
11. BIRTHPLACE (State or foreign country): CRISFIELD, MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Wm Jerone Sterling
14. MOTHER'S MAIDEN NAME: Lavina Sterling
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): ___
16. SOCIAL SECURITY NO.: 577-16-5499
17. INFORMANT Address: Robert M. Carrico

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | CONGESTIVE HEART FAILURE | 6 HRS. |
| DUE TO (b) | GENERALIZED CARCINOMATOSIS | 3 YRS. |
| DUE TO (c) | CARCINOMA OF OVARY | 4 YRS. |

175.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): RHEUMATIC HEART DISEASE

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): None
20c. TIME OF INJURY Month, Day, Year Hour o'clock a.m. p.m. None
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from AUG 6, 1960 to Present, 19__, that I last saw the deceased alive on AUG 12, 1960, and that death occurred at 9PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Arthur Shaver Jr. M.D. ADDRESS (Street, city or town, state): Branch Ave. - Clinton Md. DATE SIGNED: 8/16/60
PHYSICIAN'S NAME (Type): ARTHUR SHAVER JR. BRANCH AVE. - CLINTON MD. 8/16/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: aug 18 60
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
22d. LOCATION (City, town, or county) (State): Suitland, md.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Simmons Bros 1661 - 3d Hopkins
24a. REC'D BY REGISTRAR DATE AUG 18 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

22 nash D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

CARLYN CARRICO AUG. 16

CRISFIELD, MD. MD

Jan 11 1904 56

Training Nursing Service Testing

521-16-8444 Robert M. Carrico

CONGESTIVE HEART FAIL

GENERALIZED CHRONIC

CHRONIC OF OVAR

ATIC HEART DIS

AUG

S SHAV

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9459

Reg. Dist. No. 09432

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George General Hosp

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: MD
b. COUNTY: Pr Geo
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda 1560-2
d. STREET ADDRESS: 9807 River Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: SUSANNA Middle: B. Last: Chamberlain
4. DATE OF DEATH: Month: Aug Day: 30 Year: 1960
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 21 1883
9. AGE (If under 1 year last birthday): 77 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME: JOAB E. JACKSON
14. MOTHER'S MAIDEN NAME: Roberta Burwell
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mrs. Grace Gladden Address: 5721 67th Ave Riverdale, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple pulmonary emboli
420.0
DUE TO (b): Marked patchy atelectasis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): generalized arteriosclerotic heart dis
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): left trochanteric fracture
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour: 2 o. m. p. m. Month, Day, Year: 8-19 1960
20d. INJURY OCCURRED While at work ☐ Not while at work ☑
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Dayton Watkins M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☑
DATE SIGNED:
EXAMINER'S NAME (Type): DAYTON O WATKINS

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept 3, 1960
22c. NAME OF CEMETERY OR CREMATORY: GLENWOOD
22d. LOCATION (City, town, or county) (State): WASHINGTON D C
23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: W. W. Chambers Co. Riverdale, Md
24a. REC'D BY REGISTRAR DATE: SEP 2 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9514 — 09433

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

**1. PLACE OF DEATH**
a. COUNTY: PRINCE GEORGE'S — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Riverdale
c. LENGTH OF STAY IN 1b: D.C.A.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): LELAND MEMORIAL HOSPITAL

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
e. STATE: MARYLAND — b. COUNTY: PRINCE GEORGE'S
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MT. RAINIER
d. STREET ADDRESS: 3370 CHILLUM RD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: FELIX — Middle: PREZIOSI — Last: CIANCIARUSO

**4. DATE OF DEATH**: Month: AUG — Day: 5 — Year: 1960

**5. SEX**: MALE

**6. COLOR OR RACE**: CAUCASIAN

**7. MARRIED** ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: JULY 29, 1897

**9. AGE** (In years last birthday): 63 yrs.

IF UNDER 1 YEAR: Months: — Days: —

IF UNDER 24 HRS.: Hours: — Min.: —

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): MAINTENANCE MAN

**10b. KIND OF BUSINESS OR INDUSTRY**: UNIV. MARYLAND

**11. BIRTHPLACE** (State or foreign country): ITALY

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A

**13. FATHER'S NAME**: ALEXANDER CIANCIARUSO

**14. MOTHER'S MAIDEN NAME**: ADELE PREZIOSI

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown) (If yes give war or dates of service): NO

**16. SOCIAL SECURITY NO.**: 052-05-4834

**17. INFORMANT**: ALBERT D. MINICHELLA — Address: 2703 ARUNDEL RD MT. RAINIER, MD

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute congestive heart failure
DUE TO (b): Cardiovascular renal disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

MEDICAL CERTIFICATION

**20a. EXTERNAL CAUSE WAS** PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. — Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑ and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.

EXAMINER'S NAME (Type): James I. Boyd

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑

Address (Street, city, town, or county):

DATE SIGNED: 8-6-60

**22a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**22b. DATE THEREOF**: Aug 8, 1960

**22c. NAME OF CEMETERY OR CREMATORY**: George Washington

**22d. LOCATION** (City, or country) (State): Hyattsville, Md.

**23. FUNERAL DIRECTOR** — ADDRESS: F. Gasch's Sons Hyattsville, Md.

**24a. REC'D BY REGISTRAR** DATE: AUG 9 '60

**24b. REGISTRAR'S SIGNATURE**: Arthur L. Kraus

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9534 **CERTIFICATE OF DEATH** 09434

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): N. Hyattsville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: apt. 4 5608 - Queens Chapel Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): N. Hyattsville
d. STREET ADDRESS: 5608 Queens Chapel Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Mary Middle E. Last Clancy
4. DATE OF DEATH: Month 8 Day 24 Year 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 4/12/1874
9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Ireland
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Thomas Murphy
14. MOTHER'S MAIDEN NAME: Margaret Walsh

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: none
INFORMANT: Anna M. Clancy, Daughter Address: same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs
DUE TO (b): Hypertension — 10 yrs.
DUE TO (c): Arteriosclerosis — 20 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

331X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Senility

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec 19 55 to 20 Aug 19 60, that I last saw the deceased alive on 20 August 19 60, and that death occurred at 9 30 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE OF PHYSICIAN: Francis T. Coleman M.D. ADDRESS (Street, city or town, state): 5315 - 16th St. N.W. DATE SIGNED: 21 Aug. 60
PHYSICIAN'S NAME (Type): Francis T. Coleman M.D. Wash 11, D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/24/60
22c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet
22d. LOCATION (City, town, or county) (State): Washington, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: Malley's Funeral Home Inc. ADDRESS: Mt. Rainier Md.
24a. REC'D BY REGISTRAR DATE: AUG 29 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

1

FOR STATE HEALTH DEPT.

M

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any item is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Parts 1, 2, and 3 to the local director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form VS. M3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9460 — 0943

**1. PLACE OF DEATH**
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 1 hour
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Prince Georges General Hospital

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Seat Pleasant
d. STREET ADDRESS: 1719 - Central Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

**3. NAME OF DECEASED** (Type or print): First: Deberah — Middle: — Last: Coffey

**4. DATE OF DEATH**: Month: Aug — Day: 1 — Year: 1960

**5. SEX**: Female

**6. COLOR OR RACE**: Colored

**7. MARRIED** ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: July 28, 1959

**9. AGE** (In years last birthday): 1 yrs. — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): None

**10b. KIND OF BUSINESS OR INDUSTRY**: —

**11. BIRTHPLACE** (State or foreign country): Maryland

**12. CITIZEN OF WHAT COUNTRY?**: U. S. A.

**13. FATHER'S NAME**: Henry Ray Coffey

**14. MOTHER'S MAIDEN NAME**: Phyllis Bennett

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No

**16. SOCIAL SECURITY NO.**: None

**17. INFORMANT** — Address: Henry R Coffey, same as #2

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hemorrhage and Shock
DUE TO (b): Rupture of the Liver
DUE TO (c): —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

MEDICAL CERTIFICATION

**20a. EXTERNAL CAUSE WAS** PRIMARY ☐ or CONTRIBUTING ☐ **CAUSE OF DEATH.**

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of Item 18.): Run over by a truck

**20c. TIME OF INJURY** Hour: 5-45 p.m. Month, Day, Year: 8-1 1960

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☒

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.): Yard of house

**20f.** (City or town) (County) (State): Seat Pleasant P. G. Md.

**21. I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James F. Boyd M.D.

EXAMINER'S NAME (Type): JAMES F. BOYD

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county): —

DATE SIGNED: 8-2-60

**22a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**22b. DATE THEREOF**: 8-5-1960

**22c. NAME OF CEMETERY OR CREMATORY**: Methodist Church Cem

**22d. LOCATION** (City, town, or county) (State): Chesterfield, S. Car

**23. FUNERAL DIRECTOR**: W. W. Chambers Co. — ADDRESS: Riverdale, Md

**24a. REC'D BY REGISTRAR** DATE: AUG 4 '60

**24b. REGISTRAR'S SIGNATURE**: Arthur S. Krauss

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9461

Reg. Dist. No. 10577

1. PLACE OF DEATH
a. COUNTY Prince Geo's MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly
c. LENGTH OF STAY IN 1b DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE Md b. COUNTY Pr Geo
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper marlboro Md
d. STREET ADDRESS Box XXXXXXX 4273
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First WALTER Middle OTTO Last Cooke
4. DATE OF DEATH Month Sept. Day 20 Year 1960

5. SEX M
6. COLOR OR RACE W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Jan 24 1884
9. AGE (In years last birthday) 76 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Specialist
10b. KIND OF BUSINESS OR INDUSTRY U.S. Government
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Frank L Cooke
14. MOTHER'S MAIDEN NAME Sara Parker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Frances Cooke Address Same as Item 2. Marlboro Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: Minutes
DUE TO (b) Cardiovascular Renal Disease
DUE TO (c) Hypertension — Years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 442X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH None
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE Dayton O Watkins M.D.
EXAMINER'S NAME (Type) DAYTON O WATKINS
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 8/25/60

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 8/29/60
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery
22d. LOCATION (City, town, or county) (State) Suitland Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ritchie Bros. Upper Marlboro, Md.
24a. REC'D BY REGISTRAR DATE SEP 21 '60
24b. REGISTRAR'S SIGNATURE Arthur L. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9535 **CERTIFICATE OF DEATH** Reg. Dist. No. 09436

1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton
c. LENGTH OF STAY IN 1b 17 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION So Md Hospital Center

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md b. COUNTY Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine
d. STREET ADDRESS Rt #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Zeta Middle Cora Last Cutler
4. DATE OF DEATH Month Aug Day 24 Year 1960
5. SEX Female
6. COLOR OR RACE Cau
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Mar 13, 1903
9. AGE (In years last birthday) 57 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (State or foreign country) Iowa
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME David M. Jones
14. MOTHER'S MAIDEN NAME Frances Caroline Fish
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
INFORMANT W. M. Cutler Husband Address Rt #1 Brandywine, Md

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary embolism
DUE TO (b) with severe CHF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Thrombophlebitis, R/L + Pelvis
INTERVAL BETWEEN ONSET AND DEATH 20 hours

463X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from Aug 23, 1960, to Aug 24, 1960, that I last saw the deceased alive on Aug 24, 1960, and that death occurred at 5:40 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE Vivian Chang M.D. ADDRESS (Street, city or town, state) c/o Southern Maryland Hospital DATE SIGNED 8-24-60

PHYSICIAN'S NAME (Type) Vivian Chang Clinton, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) Bur. 22b. DATE THEREOF 8-26-60 22c. NAME OF CEMETERY OR CREMATORY Immanuel 22d. LOCATION (City, town, or county) (State) Baden, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS The Huntt Funeral Home, Waldorf, Md.
24a. REC'D BY REGISTRAR DATE AUG 30 '60
24b. REGISTRAR'S SIGNATURE Arthur S. Travis

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospitol or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/SB

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG270 9-6-60 et

9462

## CERTIFICATE OF DEATH

Reg. Dist. No. 09437

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chapel Oaks
d. STREET ADDRESS: 5703 Addison Chapel Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Esther — Middle: Q — Last: Davis

4. DATE OF DEATH: Month: Aug — Day: 29 — Year: 1960

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12/9/25

9. AGE (In years last birthday): 34 35 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Burlington, N. C.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Levi Jefferies

14. MOTHER'S MAIDEN NAME: Zula Parker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

INFORMANT: Leo Davis (Husband) — Address: 5703 Addison Chapel Road, Chapel Oaks, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of the Cervix
DUE TO (b): Metastases & uremia
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

171X

INTERVAL BETWEEN ONSET AND DEATH: Sept 1959 - 8-29-60

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug. 24, 1960, to Aug. 29, 1960, that I last saw the deceased alive on August 29, 1960, and that death occurred at 9:25 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Jorge Labarraque M.D. — ADDRESS (Street, city or town, state): 1723 M St. NW Wash D.C. — DATE SIGNED

PHYSICIAN'S NAME (Type): JORGE LABARRAQUE

22a. BURIAL, CREMATION, REMOVAL (Specify): Shipped

22b. DATE THEREOF: 9-1-1960

22c. NAME OF CEMETERY OR CREMATORY: Martin Chapel Church

22d. LOCATION (City, town, or county) (State): Burlington, N. C.

23. FUNERAL DIRECTOR'S SIGNATURE: Malvern Sidney Inc — ADDRESS: 424 R St NW DC

24a. REC'D BY REGISTRAR DATE: AUG 31 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

1

FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9463 09438

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

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1. PLACE OF DEATH
   a. COUNTY: Prince George's — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cheverly
   c. LENGTH OF STAY IN 1b: Dead on arrival
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution, residence before admission)
   a. STATE: Maryland
   b. COUNTY: Prince George's
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
   d. STREET ADDRESS: 3129 Parkway
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐ XX

3. NAME OF DECEASED (Type or print): First: Thomas — Middle: Eugene — Last: Day

4. DATE OF DEATH: Month: August — Day: 20 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 21, 1921

9. AGE (In years last birthday): 38 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrician

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Wallace E. Day

14. MOTHER'S MAIDEN NAME: Mary E. King

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unkown): Yes — (If yes give war or dates of service): WW II

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mary S. Day, Address: Same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute congestive heart failure

DUE TO (b): Subacute bacterial endocarditis

DUE TO (c): Rheumatic heart disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 416X

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.

EXAMINER'S NAME (Type): James I. Boyd

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 8/20/60

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/24/60

22c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cemetery

22d. LOCATION (City, town, or country) (State): Wheaton Md.

23. FUNERAL DIRECTOR — ADDRESS: F. Gasch's Sons Hyattsville, Md.

24a. REC'D BY REGISTRAR DATE: AUG 25 '60

24b. REGISTRAR'S SIGNATURE: Esther L. Krauss

VS. A1SME
5M 7/59

x x

x

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09439

## CERTIFICATE OF DEATH

9536 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CAMP SPRINGS (RURAL)
c. LENGTH OF STAY IN 1b: 5 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: USAF Hospital Andrews

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: Pr. Geo.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (Wash 21 DC) Forest Hgts
d. STREET ADDRESS: 117 Iroquois Way
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FRANK Middle D Last Denison

4. DATE OF DEATH: Month August Day 21 Year 1960

5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4 June 84
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fashion Decorator
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Nebraska
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James D Denison
14. MOTHER'S MAIDEN NAME: Mary Jane Fowler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Son Dwight Denison Address: 117 Iroquois Way

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): ACUTE MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: ONE HOUR
420.0
DUE TO (b): ATHEROSCLEROTIC HEART DISEASE — YEARS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): CARCINOMA OF LUNG
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 21 August, 1960, to 21 Aug., 1960, that I last saw the deceased alive on 21 August, 1960, and that death occurred at 7:45 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Jerome Tillies M.D. — ADDRESS (Street, city or town, state): USAF HOSPITAL ANDREWS — DATE SIGNED: 21 AUGUST 1960

PHYSICIAN'S NAME (Type): JEROME TILLIES, CAPT, USAF MC — ANDREWS AFB WASHINGTON 25, D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-22-60
22c. NAME OF CEMETERY OR CREMATORY: Star Hill Cemetery
22d. LOCATION (City, town, or county) (State): Groton Conn.

23. FUNERAL DIRECTOR'S SIGNATURE: Simmons Bros. — ADDRESS: 1661 Good Hope Rd SE Wash 20 DC
24a. REC'D BY REGISTRAR DATE: AUG 23 '60
24b. REGISTRAR'S SIGNATURE: Anthony L. Kunes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be [illegible] by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9537 Items 4,21 FilmG271 9-15-60 et

## CERTIFICATE OF DEATH

09440 Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Upper Marlboro
c. LENGTH OF STAY IN 1b: 1 month
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: USAF Hospital Andrews

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Upper Marlboro
d. STREET ADDRESS: 4804 Roblee Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Marybeth Middle — Last DeSantis

4. DATE OF DEATH: Month August Day 21 Year 1960

5. SEX: Female
6. COLOR OR RACE: Caucasion
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 21 July 1960
9. AGE (In years last birthday): — yrs.
IF UNDER 1 YEAR: Months 1 Days — IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): District Columbia
12. CITIZEN OF WHAT COUNTRY?: United States

13. FATHER'S NAME: Frank DeSantis
14. MOTHER'S MAIDEN NAME: Barbara A. DeSantis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): --
16. SOCIAL SECURITY NO.: N/A
INFORMANT: ~~N/A~~ Frank J. DeSantis Address 4804 Roblee Drive, Upper Marlboro, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Unknown, DOA — INTERVAL BETWEEN ONSET AND DEATH:
795.5
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Brought to USAF Hospital Andrews (DOA) by Emergency Rescue Squad
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year: Hour Unknown a. m. p. m. Aug 20 1960
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) (County) (State): Upper Marlboro (PG) Md.

21. I certify that I ottended the deceosed from 0845hrs, 19 60 to 0845, 1960, thot I lost sow the deceosed alive on N/A, 19, and that death occurred at N/A M, from the causes and on the date stoted obave.

ACTUAL SIGNATURE OF PHYSICIAN: James W. G. Carman M.D.
ADDRESS (Street, city or town, state): USAF Hosp. Andrews
DATE SIGNED: 8/29/60
PHYSICIAN'S NAME (Type): James W. G. Carman, M.D.
USAF Hosp., Andrews Air Base

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/24/60
22c. NAME OF CEMETERY OR CREMATORY: Arlington National Cem.
22d. LOCATION (City, town, or county) (State): Ft. Myer, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Ritchie Bros. Fun'l Home
ADDRESS: Upper Marlboro Md.
24a. REC'D BY REGISTRAR DATE: AUG 23 '60
24b. REGISTRAR'S SIGNATURE: Cathryn S. Krauss

9VVVVVVXVV

1

FOR STATE HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 9441 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09441

1. **PLACE OF DEATH**
   a. COUNTY: Prince George County — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mount Rainier
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 3523 37th Street

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Prince George's
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Adelphi
   d. STREET ADDRESS: 2215 University Boulevard
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HOWARD — Middle — Last DRAKE

4. DATE OF DEATH: Month August — Day 12, — Year 1960.

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: December 30 1893

9. AGE (In years last birthday): 66 yrs.
   IF UNDER 1 YEAR: Months — Days
   IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist

10b. KIND OF BUSINESS OR INDUSTRY: Printing

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ALVA DRAKE unknown

14. MOTHER'S MAIDEN NAME: ELMOINA BENEWAY unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No

16. SOCIAL SECURITY NO. (If yes give wave or dates of service): 140-14-7789

17. INFORMANT: Arthur H. D. Williams — Address: 5822 Greenlawn Dr. Bethesda, Md.

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac Tamponade — INTERVAL BETWEEN ONSET AND DEATH

4427

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Rupture of the heart

DUE TO (c): Cardiovascular renal disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Aortic valvular disease- rheumatic

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I Boyd M.D.

EXAMINER'S NAME (Type): JAMES I. BOYD, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county): August 12, 1960.

DATE SIGNED

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-16-1960

22c. NAME OF CEMETERY OR CREMATORY: Highlands Mill

22d. LOCATION (City, town, or country) (State): Highlands, New York

23. FUNERAL DIRECTOR — ADDRESS: W. W. CHAMBERS CO., Riverdale, Md.

24a. REC'D BY REGISTRAR DATE: AUG 18 '60

24b. REGISTRAR'S SIGNATURE: Arthur L Kraus

Aortic valvular disease- rheumatic

Cardiovascular renal disease

Rupture of the heart

Cardiac Tamponade

1140-1141-1759 Arthur H. D. Williams Bethesda, Md.

Medical Printing New York U.S.A.

Male White Deceased 12 1958 65

NONARD DRAKE Age 12, 60.

Mount Rainier Adelphi

7523 17th Street 2219 University Boulevard

Prince George County Maryland Prince George's

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9538 **CERTIFICATE OF DEATH** Reg. Dist. No. 09442

1. **PLACE OF DEATH** a. COUNTY: PRINCE GEORGES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CAMP SPRINGS
c. LENGTH OF STAY IN 1b: 1 Mo. 17 Da.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: USAF HOSP ANDREWS

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ~~PRINCE GEORGES~~ Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL WALDORF 08X 2
d. STREET ADDRESS: APT 2 BLUE BIRD INN
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First MARIE Middle WADE Last ELLIOTT
4. **DATE OF DEATH**: Month AUGUST Day 5 Year 1960
5. SEX: FEMALE
6. COLOR OR RACE: NEG
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 13 AUGUST 1930
9. AGE (In years last birthday): 29 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: NONE
11. BIRTHPLACE (State or foreign country): PITTSBURG, PA
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: RICHARD L. WADE
14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
INFORMANT Address: HERBERT ELLIOTT, APT 2 BLUE BIRD INN, WALDORF MD

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARCINUMA, METASTATIC, GENERALIZED
DUE TO (b): CARCINUMA OF RIGHT OVARY
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

175.0

INTERVAL BETWEEN ONSET AND DEATH: ABOUT 9 MONTHS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 19 JUNE, 1960, to 5 AUGUST, 1960, that I last saw the deceased alive on 5 AUGUST, 1960, and that death occurred at 5:10P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Charles S. Moon M.D. ADDRESS (Street, city or town, state): USAF HOSP ANDREWS DATE SIGNED: 5 AUGUST 1960

PHYSICIAN'S NAME (Type): CHARLES S. MOON, CAPT USAF MC USAF HOSP ANDREWS, ANDREWS AFB, WASH 25 DC

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 8-11-60
22c. NAME OF CEMETERY OR CREMATORY: High Wood
22d. LOCATION (City, town, or county) (State): Pittsburgh Penn.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: JOHN T. RHINES CO - 3015 - 12 ST. NE WASHINGTON, D.C.
24a. REC'D BY REGISTRAR DATE: AUG 12 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospitol or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9539 9539

## CERTIFICATE OF DEATH

09443

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANDREWS AIR FORCE BASE
c. LENGTH OF STAY IN 1b: 53 MIN
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: USAF HOSP ANDREWS, WASH 25, DC

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: DISTRICT OF COLUMBIA — b. COUNTY: P. Geo.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON DC
d. STREET ADDRESS: 3302 BOONES LANE,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: NEWBORN — Middle: — Last: ENNISS

4. DATE OF DEATH: Month: 8 — Day: 25 — Year: 1960

5. SEX: Female

6. COLOR OR RACE: Cauc.

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 25 Aug. 60

9. AGE (In years last birthday): NB yrs. — IF UNDER 1 YEAR: Months: Newborn — Days: — IF UNDER 24 HRS.: Hours: — Min: 53

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: United States

13. FATHER'S NAME: ENNISS, ERNEST A.

14. MOTHER'S MAIDEN NAME: RITTUE, VALORIE J.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NA — (If yes, give war or dates of service): NA

16. SOCIAL SECURITY NO.: NA

INFORMANT: ERNEST A ENNIS(FATHER) — Address: SAME AS #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Pulmonary Atelectasis
762.5
DUE TO (b): Prematurity
Conditions, if ony, which gave rise to immediate couse (o), stoting the underlying couse last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 53 MIN / 53 Min

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Doy, Year 19

20d. INJURY OCCURRED While ot work ☐ Not while ot work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify thot I ottended the deceased from 25 August, 1960, to 25 August, 1960 thot I lost sow the deceased alive on 25 August, 1960, and that deoth occurred at 1:28 P.M., from the couses ond on the date stated above.

ACTUAL SIGNATURE: James M Finneran M.D.

ADDRESS (Street, city or town, state): USAF HOSP ANDREWSN

DATE SIGNED: 25 AUGUST 1960

PHYSICIAN'S NAME (Type): JAMES M FINNERAN, CAPT USAF MC

USAF HOSP ANDREWS ANDREWS AFB WASH 25 DC

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

22b. DATE THEREOF: 8-30-60

22c. NAME OF CEMETERY OR CREMATORY: D. C. Morgue

22d. LOCATION (City, town, or county) (State): Washington, D. C.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS

24a. REC'D BY REGISTRAR DATE: AUG 31 '60

24b. REGISTRAR'S SIGNATURE: Clifford S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be [illegible] by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use os the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registror prior to burial, cremotion, or removol, and in any event within 72 hours after death.

VS A1S (4)
15M 9/SB

2050367XVI

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9464

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09444
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Prince Geo Co. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly
c. LENGTH OF STAY IN this Institution DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Geo General Hospital

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE md b. COUNTY Pr Geo
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cottage City
d. STREET ADDRESS 3716-43 ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First HENRY Middle Last EPSTEIN
4. DATE OF DEATH Month Aug Day 21 Year 1960

5. SEX M
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH 5-20 1900
9. AGE (If under 1 year last birthday) 60 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman
10b. KIND OF BUSINESS OR INDUSTRY arcade
11. BIRTHPLACE (State or foreign country) Baltimore Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME MORRIS EPSTEIN
14. MOTHER'S MAIDEN NAME MARY LIPSTITZ

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 578057142
17. INFORMANT Leonard Resnick Address 3716-43ave Cottage City Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Edema
DUE TO (b) Arteriosclerotic Cardiovascular dis 4 Yrs
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
422.1
INTERVAL BETWEEN ONSET AND DEATH unkn.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
asthma
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE Dayton O Watkins M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 8-21-60
EXAMINER'S NAME (Type) DAYTON O WATKINS

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 8-23-60
22c. NAME OF CEMETERY OR CREMATORY Herring Run
22d. LOCATION (City, town, or county) (State) Balto Md

23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis Jr
ADDRESS 2100 Guilford Place
24a. REC'D BY REGISTRAR DATE AUG 23 '60
24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

See: Birth Cert. et

## CERTIFICATE OF DEATH

9465

09445 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 3 hrs 25 Min.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Pri. Geo.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Seat Pleasant
d. STREET ADDRESS: 908 Addison-Chappel Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Baby — Middle: Girl (A) — Last: Everett

4. DATE OF DEATH: Month: August — Day: 6 — Year: 19 60

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8-6-60

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months — Days: 3 Hours — IF UNDER 24 HRS.: Min. 25

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Cheverly, Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Donald Brown

14. MOTHER'S MAIDEN NAME: Doris Everett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

INFORMANT — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity (viable birthweight)
DUE TO (b): Atelasis
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug. 6, 19 60, to Aug. 6, 19 60 that I last saw the deceased alive on Aug. 6, 19 60, and that death occurred at 7 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas A. Christensen M.D.

ADDRESS (Street, city or town, state) DATE SIGNED

PHYSICIAN'S NAME (Type): Dr. Thomas A. Christensen M.D. 6905 Baltimore Ave. College Park, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

22b. DATE THEREOF: Aug 19 1960

22c. NAME OF CEMETERY OR CREMATORY: Prince Georges Memorial Park

22d. LOCATION (City, town, or county) (State): Cheverly Md

23. FUNERAL DIRECTOR'S SIGNATURE: Henry W. Parrish Adm

ADDRESS

24a. REC'D BY REGISTRAR DATE: AUG 22 '60

24b. REGISTRAR'S SIGNATURE: Clifton S. Knuth

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

217722 4XVO

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9466 See: Birth Cert. of **CERTIFICATE OF DEATH** 09446

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

**1. PLACE OF DEATH**
a. COUNTY: Prince Georges County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 3 hrs 15 Min.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince Georges General Hospital

**2. USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Pri. Geo.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Seat Pleasant
d. STREET ADDRESS: 908 Addison-Chappel Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

**3. NAME OF DECEASED** (Type or print): First: Baby Girl (B) Middle: Last: Everett

**4. DATE OF DEATH**: Month: August Day: 6 Year: 19 60

**5. SEX**: Female

**6. COLOR OR RACE**: Colored

**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: 8-6-60

**9. AGE** (In years last birthday) yrs.

IF UNDER 1 YEAR: Months: Days: 5 Hours: Min. 15

IF UNDER 24 HRS.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired)

**10b. KIND OF BUSINESS OR INDUSTRY**

**11. BIRTHPLACE** (State or foreign country): Cheverly, Md.

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Donald Brown

**14. MOTHER'S MAIDEN NAME**: Doris Everett

**15. WAS DECEASED EVER IN U. S. ARMED FORCES?** (Yes, no, or unknown) (If yes, give war or dates of service)

**16. SOCIAL SECURITY NO.**

**17. INFORMANT** Address

## MEDICAL CERTIFICATION

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumothorax (acute one breath.) — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b): Atelectasis
DUE TO
(c):

762.5

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☐

**20a. ACCIDENT WAS UNDERLYING** ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour o. m. p. m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not while at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from Aug. 6 19 60 to Aug. 6 19 60 that (I) (we) last saw the deceased alive on Aug. 6 19 60 and that death occurred at 7 PM, from the causes and on the date stated above.

**22a. SIGNATURE**: Thomas A. Christensen M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED**

**22c. PHYSICIAN'S NAME** (Type): Dr Thomas A. Christensen M.D.

**22d. ADDRESS**: 6905 Baltimore Ave. College Park Md.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF**: 8/19/1960

**23c. NAME OF CEMETERY OR CREMATORY**: Prince Georges Memorial Park

**23d. LOCATION** (City, town, or county) (State): Cheverly Md

**24. FUNERAL DIRECTOR'S SIGNATURE**: Henry W. Brown Jr.

**ADDRESS**: Adm.

**25a. REC'D BY REGISTRAR** DATE: AUG 22 60

**25b. REGISTRAR'S SIGNATURE**: Chas. S. Mans

22/2222 5XNo

1

FOR STATE HEALTH DEPT.

M

I

**TO DIRECTOR MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If [illegible] delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9540

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09447

**1. PLACE OF DEATH**
a. COUNTY: PRINCE GEORGE'S — STATE: MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): LANHAM
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): PRESLEY RD. RT. 1.

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: PRINCE GEORGE'S
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LANHAM
d. STREET ADDRESS: 1312 PRESLEY RD RT. 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: WILLIAM — Middle: BOWYER — Last: FITZGERALD

**4. DATE OF DEATH**: Month: AUG — Day: 7 — Year: 1960

**5. SEX**: MALE

**6. COLOR OR RACE**: CAUCASIAN

**7. MARRIED** ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: APRIL 30. 1907

**9. AGE** (In years last birthday): 53 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): GROUND MAN

**10b. KIND OF BUSINESS OR INDUSTRY**: ELECTRICAL CONST.

**11. BIRTHPLACE** (State or foreign country): VIRGINIA.

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A

**13. FATHER'S NAME**: WILLIAM H. FITZGERALD

**14. MOTHER'S MAIDEN NAME**: MARY E. COFFEY

SAME AS #2

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): YES
(If yes give wer or dates of service): WORLD WAR 2

**16. SOCIAL SECURITY NO.**: 231-05-5772

**17. INFORMANT** Address: HALSEY C. FITZGERALD

SAME AS #2.

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hemorrhage and shock
976X
DUE TO (b): Gunshot wound of chest
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

MEDICAL CERTIFICATION

**20a. EXTERNAL CAUSE WAS** PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.): Shot self with shot gun

**20c. TIME OF INJURY** Hour: 11 a.m. p.m. — Month, Day, Year: 8-6 1960

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, ferm, factory, street, office bldg., etc.): In wooded area

**20f.** (City or town): Lanham (County): P.G. (State): Md.

**21. I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE: James I. Boyd M.D.

EXAMINER'S NAME (Type): James I. Boyd

Address (Street, city, town, or county):

DATE SIGNED: 8-9-60

**22a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**22b. DATE THEREOF**: 8-11-1960

**22c. NAME OF CEMETERY OR CREMATORY**: Arlington National

**22d. LOCATION** (City, town, or country): Arlington, (State): Virginia.

**23. FUNERAL DIRECTOR**: W. W. Chambers & Sons Funeral Dir. Md.
ADDRESS:

**24a. REC'D BY REGISTRAR** DATE: AUG 11 '60

**24b. REGISTRAR'S SIGNATURE**: Arthur S. Kraus

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9467

## CERTIFICATE OF DEATH

09448
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Pro George's

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md.

c. LENGTH OF STAY IN 1b: 26 years

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2604 Cheverly avenue

d. STREET ADDRESS 2604 Cheverly avenue

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First John Middle Raymond Last Fletcher

4. DATE OF DEATH: Month August Day 27, Year 19 60

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 25, 1900

9. AGE (In years last birthday) 60 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Judge

10b. KIND OF BUSINESS OR INDUSTRY: Prince George's Co

11. BIRTHPLACE (State or foreign country): Washington D. C.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: John Langdon Fletcher

14. MOTHER'S MAIDEN NAME: Grace Etta Fields

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

INFORMANT: Emma L Fletcher Address: Cheverly Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Lobar Pneumonia
DUE TO
(b) Pulmonary Edema
DUE TO
(c) Ca Thyroid & Brain & Soft Hemiplegia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 193.0

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March, 1960, to Aug 27, 1960 that I last saw the deceased alive on Aug 27, 19____, and that death occurred at ____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE Louis M. Jimal M.D.

ADDRESS (Street, city or town, state) 4008 Bladensburg Rd., Cottage City, Md.

DATE SIGNED 8/28/60

PHYSICIAN'S NAME (Type) Louis M. Jimal M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF Aug 30, 1960

22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery

22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS F. Gasch's Sons Hyattsville, Maryland.

24a. REC'D BY REGISTRAR DATE AUG 31 '60

24b. REGISTRAR'S SIGNATURE Arthur L. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9468

09449

## CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Upper Marlboro
d. STREET ADDRESS: 7177 Whitehouse Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Baby; Middle: Boy; Last: Ford

4. DATE OF DEATH: Month: August; Day: 21; Year: 19 60

5. SEX: Male

6. COLOR OR RACE: Black

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 19 Aug 1960

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months: 2 Days; IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Nelson H Ford

14. MOTHER'S MAIDEN NAME: Margaret Medley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mother — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity
DUE TO
776x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug 19 19 60, to Aug 21 19 60, that (I) (we) last saw the deceased alive on Aug 21 19 60, and that death occurred at 1,25 A.M. from the causes and on the date stated above.

22a. SIGNATURE: John W. Perkins M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Dr. John Perkins

22d. ADDRESS: 5301 Hamilton St. Hyattsville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: 8--24--60

23c. NAME OF CEMETERY OR CREMATORY: Prince George's Gen. Hosp.

23d. LOCATION (City, town, or county) (State): Cheverly, MARYLAND

24. FUNERAL DIRECTOR'S SIGNATURE: Harry W. Penn Jr.

ADDRESS: Harry W. Penn, Jr. Administrator

25a. REC'D BY REGISTRAR DATE SEP 7 '60

25b. REGISTRAR'S SIGNATURE: Arthur L. Travis

2077195x12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 1SM 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9469 — Reg. Dist. No. 09450

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: D. O. A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Eastpines
d. STREET ADDRESS: 5901 67th Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frieda — Middle: Hedwig — Last: Franke

4. DATE OF DEATH: Month: August — Day: 30, — Year: 19 60

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 1, 1872

9. AGE (In years last birthday): 88 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? Germany

13. FATHER'S NAME: Truettott Woohlgemut

14. MOTHER'S MAIDEN NAME: Augusta Frommhod

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
If yes, give war or dates of service:

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Max Franke (Husband) Same as # 2 — Address

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral accident — INTERVAL BETWEEN ONSET AND DEATH: Inst
DUE TO (b): Generalized arteriosclerosis
DUE TO (c): Cerebral Sclerosis — years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

331X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Dayton Watkins M.D.
EXAMINER'S NAME (Type): DAYTON WATKINS

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 9/1/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 9/3/60
22c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln
22d. LOCATION (City, town, or county) (State): Colmar Manor, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: F. Gasch's Sons — ADDRESS: Hyattsville, Maryland

24a. REC'D BY REGISTRAR DATE: SEP 6 '60

24b. REGISTRAR'S SIGNATURE: Clifton L. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9513

## CERTIFICATE OF DEATH

09451 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland. b. COUNTY: Pro George's

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale Md

c. LENGTH OF STAY IN 1b: 35 years

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale Md.

d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 4903 Ravenswood Road

d. STREET ADDRESS: 4903 Ravenswood Road

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ethel Middle: Adel Lost: Freeland

4. DATE OF DEATH: Month: August Day: 22, Year: 19 60

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 26, 1883

9. AGE (In years last birthday): 76 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Gift Shop

11. BIRTHPLACE (State or foreign country): South Dekota

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: George W Freeland

14. MOTHER'S MAIDEN NAME: Hattie Sebbins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

INFORMANT: Isabel Freeland Address: Riverdale, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Accident

420.0

DUE TO (b): Arteriosclerotic Heart Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 2-4, 1940, to 8-21, 1960 that I last saw the deceased alive on 8-20, 1960, and that death occurred at M, from the causes and on the date stated above.

ACTUAL SIGNATURE: A A Deitz M.D.

ADDRESS (Street, city or town, state): Hyattsville Md

DATE SIGNED: 8/22/60

PHYSICIAN'S NAME (Type): AA Deitz

Hyattsville, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/24/60

22c. NAME OF CEMETERY OR CREMATORY: Ft Lincoln Cemetery

22d. LOCATION (City, town, or county) (State): Colmar Manor, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: F. Gasch's Sons Hyattsville, Maryland.

24a. REC'D BY REGISTRAR DATE: AUG 26 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

**TO HOSPITAL OR ATTENDING PHYSICIAN**: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

**TO FUNERAL DIRECTOR**: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9470 — Reg. Dist. No. 09452

1. PLACE OF DEATH
a. COUNTY: Pr Geo — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHEVERLY
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): PRINCE Geo General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Pr Geo.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 3104 Shepherd St. 47
d. STREET ADDRESS: Mt. Rainier, Md.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First RALPH Middle WYLIE Last Frey
4. DATE OF DEATH: Month AUG Day 28 Year 1960

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: JULY 25 1889
9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): WASHINGTON DC
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: LOUIS A. FREY
14. MOTHER'S MAIDEN NAME: FLORIDA V WYLIE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 577-40-6333
17. INFORMANT: (Signature) RALPH WYLIE FREY JR (Address) 1114 YALE Ave Mt Rainier Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | Cerebral accident | Hours |
| DUE TO (b) | Hypertensive Cardio Vascular disease | 10 years |
| DUE TO (c) | | |

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): None
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remoins described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Naturol couses ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Dayton Watkins M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED 8-22-60
EXAMINER'S NAME (Type): DAYTON O WATKINS

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/25/60
22c. NAME OF CEMETERY OR CREMATORY: Rock Creek
22d. LOCATION (City, town, or county) (State): Washington, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: Malley's Funeral Home, Inc. — ADDRESS: Mt. Rainier Md.
24a. REC'D BY REGISTRAR — DATE AUG 29 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S)
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9541

09453

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glenn Dale (rural)
c. LENGTH OF STAY IN 1b: 22 days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Glenn Dale Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D. C.
b. COUNTY: -
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 625 K. St., S. E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary; Middle: -; Last: Green

4. DATE OF DEATH: Month: 8; Day: 17; Year: 1960

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ Unknown

8. DATE OF BIRTH: 8/25/1853?

9. AGE (In years last birthday): 106? yrs.
IF UNDER 1 YEAR — Months: -; Days: -
IF UNDER 24 HRS. — Hours: -; Min.: -

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Unknown

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -

16. SOCIAL SECURITY NO.: -

17. INFORMANT: Muriel Marshall
Address: 2550 Stanton Rd., S. E., Washington, D. C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary embolism — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
(b) Phlebothrombosis, left leg, amputation stump — 1 week
DUE TO
(c) Septic gangrene, left leg — unk.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerotic heart disease

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Doy, Yeor 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7/26/60 1:00 P. M. to 8/17/60 ~~19~~, that (I) (we) last saw the deceased alive on 8/17/60 ~~19~~, and that death occurred at P. M, from the causes and on the date stated above.

22a. SIGNATURE: Moe Weiss M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐
22b. DATE SIGNED: 8/17/60

22c. PHYSICIAN'S NAME (Type): Moe Weiss, M. D.

22d. ADDRESS: Glenn Dale Hospital, Glenn Dale, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE THEREOF: 8/19/60
23c. NAME OF CEMETERY OR CREMATORY:
23d. LOCATION (City, town, or county) (State): Washington, D. C.

24. FUNERAL DIRECTOR'S SIGNATURE: Henry W. Joynes
ADDRESS: 1164 14th St. NW Washington DC
25a. REC'D BY REGISTRAR DATE: AUG 22 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9542

## CERTIFICATE OF DEATH

Reg. Dist. No. 08454

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chapel Oaks
c. LENGTH OF STAY IN 1b: 1 mo.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 1403 - 57th Place

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C.
d. STREET ADDRESS: 4319 - Anacostia Ave. N.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Chauncey — Middle: — Last: Grimes

4. DATE OF DEATH: Month: Aug. — Day: 30 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 6, 1889

9. AGE (In years last birthday): 71 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Building Laborer

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Govt.

11. BIRTHPLACE (State or foreign country): Va.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Keeling Grimes

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

INFORMANT: Martha E. Grimes — Address: 4319 Anacostia Ave. N.E.

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Left Ventricular Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 wks.
DUE TO (b): Hypertensive Cardio Vascular Disease — Unknown
DUE TO (c):

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Partial Paralysis - Arthritis Deformens (Generalized)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from July 30, 1960, to Aug. 30, 1960 that I last saw the deceased alive on Aug. 28, 1960, and that death occurred at 5:[illegible] P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: John W. Robinson, M.D. — ADDRESS (Street, city or town, state): John W. Robinson, M.D. 1001 Eastern Ave. N.E. Washington 27, D.C. — DATE SIGNED: 8/30/60

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept 3, 1960
22c. NAME OF CEMETERY OR CREMATORY: Woodlawn Cem.
22d. LOCATION (City, town, or county) (State): 4600 Bennning Rd. N.E. D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert Campbell — ADDRESS: 442 M St. NW.

24a. REC'D BY REGISTRAR — DATE: SEP 1 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kruna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/5B

1

FOR STATE HEALTH DEPT.

M

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**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any ... is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the fu... director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9471 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 09455

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cheverley
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Prince Georges' Gen Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 31 Hillside
d. STREET ADDRESS: 1204 48th Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Raymond — Middle: Valentine — Last: GRIMES

4. DATE OF DEATH: Month: Aug — Day: 18 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 27, 1882

9. AGE (In years last birthday): 78 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Gardiner

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Navy

11. BIRTHPLACE (State or foreign country): District of Columbia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Richard F. Grimes

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or defes of service): Unknown

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs Ruth Grimes — Address: same as # 2

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH

442x

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): Cardiovascular renal disease

DUE TO

(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.

EXAMINER'S NAME (Type): James I. Boyd

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED: August 18, 1960

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-20-1960

22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

22d. LOCATION (City, town, or county) (State): Suitland, Md

23. FUNERAL DIRECTOR: W. W. Chambers Eso. — ADDRESS: Riverdale, Md

24a. REC'D BY REGISTRAR — DATE: AUG 19 '60

24b. REGISTRAR'S SIGNATURE: Arthur L Kraus

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9543

## CERTIFICATE OF DEATH

Reg. Dist. No. 09456

1. PLACE OF DEATH
a. COUNTY: Prince George's County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Temple Hill, Maryland
c. LENGTH OF STAY IN 1b: 25 Yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 5400- Fisher Road S.E.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Pr. Geo's. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Temple Hill , Maryland
d. STREET ADDRESS: 5400- Fisher Road S.E.
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First MARY — Middle E. — Last HABEEB

4. DATE OF DEATH: Month August — Day 28th — Year 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 1st March 1870
9. AGE (In years last birthday): 90 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Domestic
11. BIRTHPLACE (State or foreign country): El-Knessie, Lebanon.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Ayout Asmar
14. MOTHER'S MAIDEN NAME: Frusina Haber

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
INFORMANT: Naseef E. Habeeb, Same as #2. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis. — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Arterio sclerotic Cardio Vascular disease
DUE TO (c): old age
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4-20-1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from aug 8, 1960, to aug 28, 1960, that I last saw the deceased alive on aug 28 6 A.M. 1960, and that death occurred at 6:30 A.M, from the causes and on the date stated above.

ACTUAL SIGNATURE: D. Etienne Szollosi, M.D. — ADDRESS (Street, city or town, state): 2-Parkway Drive Forest Heights, Md. — DATE SIGNED: 8/28/60

PHYSICIAN'S NAME (Type): Etienne Szollosi — 2-Parkway Drive Forest Heights, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug.31st. 1960
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
22d. LOCATION (City, town, or county) (State): Suitland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Simmons Brothers — ADDRESS: 1661- Good Hope Rd. SE Washington, D.C.
24a. REC'D BY REGISTRAR DATE: AUG 30 '60
24b. REGISTRAR'S SIGNATURE: Clifton L. Kinna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9515 Item 8 Film 6271 9-19-60 et 09457

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RIVERDALE
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: LELAND MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: Pro George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): KENTLAND
d. STREET ADDRESS: 7584 HAWTHORNE ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY Middle ELIZABETH Last HALL

4. DATE OF DEATH: Month AUGUST Day 26 Year 1960

5. SEX: FE

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6/9/86 1896

9. AGE (In years last birthday): 64 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: ARTHUR TUCKER

14. MOTHER'S MAIDEN NAME: ELIZABETH PEACOCK

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT (Address): HOSPITAL RECORD

### MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Days

DUE TO (b): Arteriosclerotic Heart Dis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Diabetes Mellitus

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ____ 19__ to aug 26 1960, that (I) (we) last saw the deceased alive on aug 26 1960, and that death occurred at 6:45 p.M, from the causes and on the date stated above.

22a. SIGNATURE: L W Malin M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8-31-60

22c. PHYSICIAN'S NAME (Type): L W Malin MD

22d. ADDRESS: Riverdale, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/30/60

23c. NAME OF CEMETERY OR CREMATORY: Mt Olivet Cemetery

23d. LOCATION (City, town, or county) (State): Washington D. C.

24. FUNERAL DIRECTOR'S SIGNATURE: J. Gasch sons

ADDRESS: Riverdale Md

25a. REC'D BY REGISTRAR DATE: AUG 31 '60

25b. REGISTRAR'S SIGNATURE: Clifton A. Pierce

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9544

## CERTIFICATE OF DEATH

09458
Reg. Dist. No.

M

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CAMP SPRINGS(RURAL)
c. LENGTH OF STAY IN 1b: 11 HRS 51 MIN
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: USAF HOSPITAL ANDREWS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: DISTRICT OF COLUMBIA
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON DC
d. STREET ADDRESS: "&L' 2718-2nd St, SE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES — Middle CONNER — Last HAMILTON

4. DATE OF DEATH: Month AUGUST — Day 24 — Year 1960

5. SEX: MALE

6. COLOR OR RACE: CAUCASIAN

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 24nAUGUST 1960

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours 11 — Min. 51

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NA

10b. KIND OF BUSINESS OR INDUSTRY: NA

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOHN R HAMILTON

14. MOTHER'S MAIDEN NAME: DORIS A WILLIAMS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
If yes, give war or dates of service: NA

16. SOCIAL SECURITY NO.: NONE

INFORMANT — Address

1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Shock, post operative — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs
DUE TO
(b): Omphalocele — 12 hrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

560.2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Doy, Yeor 19

20d. INJURY OCCURRED While ot work ☐ Not while ot work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

1

21. I **certify** thot I ottended the deceased from 24 Aug, 1960, to 24 Aug, 1960, that I last sow the deceased alive on 24 Aug, 1960, and that death occurred ot 1945 M, from the causes ond on the dote stoted obove.

ACTUAL SIGNATURE: John A. Moore M.D. — ADDRESS (Street, city or town, state): USAF HOSPITAL ANDREWS — DATE SIGNED: 24 AUGUST 60

PHYSICIAN'S NAME (Type): JOHN A MOORE, MAJOR USAF MC — USAF HOSP ANDREWS ANDREWS AFB, WASH 25 DC

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 29 Aug. 1960
22c. NAME OF CEMETERY OR CREMATORY: Arlington National Cem.
22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: N. J. Rinaldi — ADDRESS: Rinaldi Funeral Home, Inc. 816 H St., NE, Wash. 2, D.C.

24a. REC'D BY REGISTRAR DATE: AUG 30 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within [illegible] hours after death. Page 4 may be obtained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

2050251XV4

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9434 Item 1 Film 271 9-15-60 et

## CERTIFICATE OF DEATH

09459 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: PRINCE GEO CO. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
c. LENGTH OF STAY IN 1b: 6 weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Fairfax Nursing Home 3304 LANCER DRIVE

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale
d. STREET ADDRESS: 6904 Beacon Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): LAST HART; First MICHAEL; Middle JOHN
4. DATE OF DEATH: Month AUG; Day 22; Year 1960

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10/28/59
9. AGE (In years last birthday): 00/12 yrs.
IF UNDER 1 YEAR: Months 10; Days; IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Philip J. Hart
14. MOTHER'S MAIDEN NAME: Jewel Harper

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NO
17. INFORMANT: Mrs Jewel Harper Hart Address: 6904 Beacon Pl. Riverdale, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): HYDROCEPHALUS — INTERVAL BETWEEN ONSET AND DEATH: LIFE.

344.x

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): GANGRENE, DRY, OF RIGHT FOOT
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 18 July, 1960 to 22 August, 1960, that I last saw the deceased alive on 22 August, 1960, and that death occurred at 2:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE OF PHYSICIAN: Joseph F. McDonald M.D.
ADDRESS (Street, city or town, state): 7309 Riggs Road Hyattsville, Md.
DATE SIGNED:
PHYSICIAN'S NAME (Type): JOSEPH F. McDONALD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-24-1960
22c. NAME OF CEMETERY OR CREMATORY: Washington National
22d. LOCATION (City, town, or county) (State): Suitland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: CHAMBERS FUNERAL HOME
ADDRESS: Riverdale, Md.
24a. REC'D BY REGISTRAR DATE: AUG 30 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Harris

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

9VVVVVVXVV

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9445 — 09460 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): none

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE Md — b. COUNTY Pr Geo
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville
d. STREET ADDRESS 5733-29th Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHESTER — Middle A — Last HENNIGAR
4. DATE OF DEATH: Month August — Day 25 — Year 1960

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug 5 1905
9. AGE (In years last birthday): 55 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Steelworker
10b. KIND OF BUSINESS OR INDUSTRY: Building
11. BIRTHPLACE (State or foreign country): Nova Scotia Canada
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: unknown
14. MOTHER'S MAIDEN NAME: Mary (?)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: James Kohler — Address 7210 - Hanover Rd Hyattsville Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Wounds Multiple & — INTERVAL BETWEEN ONSET AND DEATH: inst
DUE TO (b): Severe - Amputation of leg
DUE TO (c): & Arm. Disembowled
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Subject driving a Truck hit by a train
20c. TIME OF INJURY: Hour 4:05 a. m. p. m. — Month, Day, Year 8-25 1960
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): RR Crossing
20f. (City or town) — (County) P.G. — (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE Dayton O Watkins, M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED
EXAMINER'S NAME (Type) DAYTON O. WATKINS — 8-26-60

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 8-27-60
22c. NAME OF CEMETERY OR CREMATORY: FORT LINCOLN CEM.
22d. LOCATION (City, town, or county) (State): COTTAGE CITY, MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE: Martin W. Hysong Co. Inc. — ADDRESS: WASH. D.C. 1300-N ST. N.W
24a. REC'D BY REGISTRAR DATE AUG 29 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9545

## CERTIFICATE OF DEATH

09461 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glenarden
c. LENGTH OF STAY IN 1b: 25 yr
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 75th & Lincoln Ave

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md.
b. COUNTY: Pr. Geo.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glenarden — 35
d. STREET ADDRESS: 75th & Lincoln Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Alphonso — Middle: Francis — Last: Henson

4. DATE OF DEATH: Month: Aug. — Day: 24 — Year: 1960

5. SEX: M/o

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 19 1937

9. AGE (In years last birthday): 23 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: John Henson

14. MOTHER'S MAIDEN NAME: Bernice C. Henson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Bernice C. Henson — Address: Glenarden, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonitis — INTERVAL BETWEEN ONSET AND DEATH: 2 wks
DUE TO (b): Elephantiasis @ Neurofibromatosis — 13 yrs
DUE TO (c): —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

468.3

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1959, 19—, to Aug, 1960, that I last saw the deceased alive on Aug 24, 1960, and that death occurred at 1115 P. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Dr. Henry A. Wise Jr. M.D. — ADDRESS (Street, city or town, state): Lanham, Md. — DATE SIGNED: 8/24/60

PHYSICIAN'S NAME (Type): Henry A. Wise Jr. — 9005 Volta St., Lanham, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 8-27-60

22c. NAME OF CEMETERY OR CREMATORY: Mt Ahmt

22d. LOCATION (City, town, or county) (State): Washington DC

23. FUNERAL DIRECTOR'S SIGNATURE: Harry S. Washington — ADDRESS: 4925 Deane Ave NE

24a. REC'D BY REGISTRAR DATE: AUG 29 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Nunes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9435

09462

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
c. LENGTH OF STAY IN 1b: 3+ yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 8005 14th Avenue

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 8005-14th Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Myra — Middle: J. — Last: Herndon

4. DATE OF DEATH: Month: August — Day: 19 — Year: 19 60

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 20, 1873

9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Albert Yowell

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: No

17. INFORMANT — Address: Mrs. Mamie S. Knott- 8005 14th Avenue Hyattsville, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | Heart Failure | 1 yr. |
| DUE TO (b) | Arteriosclerotic Heart Disease | 20 yrs. |
| DUE TO (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug. 1952 to Aug 19, 1960, that (I) (we) last saw the deceased alive on June 9 1960, and that death occurred at 6:35 PM, from the causes and on the date stated above.

22a. SIGNATURE: Arthur S. Bresler M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8-19-60

22c. PHYSICIAN'S NAME (Type): Arthur S. Bresler

22d. ADDRESS: 533 Riggs Rd., N. E., Washington, D. C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE THEREOF: 8/21/60

23c. NAME OF CEMETERY OR CREMATORY: --

23d. LOCATION (City, town, or county) (State): Standardsville, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: The S.H. Hines Co.- 2901 14th St., N.W. Washington 9, D.C.

25a. REC'D BY REGISTRAR DATE: AUG 23 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1

FOR STATE HEALTH DEPT.

M

X

I

2

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9546 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 09463

**TO DUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glass Manor
c. LENGTH OF STAY IN 1b: Transient
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 316 Reseld Ct. (In front of)

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: District of Columbia — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 829 Quincey St. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

47 X →

| 3. NAME OF DECEASED (Type or print) First | Middle | Last | 4. DATE OF DEATH Month | Day | Year |
|---|---|---|---|---|---|
| Leo | Francis | HINES | Aug | 18 | 1960 |

| 5. SEX | 6. COLOR OR RACE | 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | IF UNDER 1 YEAR Months / Days | IF UNDER 24 HRS. Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | | 17 Sept 1899 | 60 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Mail Carrier | Retired | ~~Maryland~~ W. Va. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| John Hines | Margaret E, Stewart |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) | (If yes give wer or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|---|
| Yes | W.W.# 2 | 578-56-2661 | Personal Papers |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH

4 42X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Cardiovascular renal disease

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arthosis of lines — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

| 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19 | 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
|---|---|---|---|---|---|
| | | | | | |

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐

ACTUAL SIGNATURE: James I Boyd M.D. — DATE SIGNED

EXAMINER'S NAME (Type): James I. Boyd — Address (Street, city, town, or county): 8/19/60

| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or country) (State) |
|---|---|---|---|
| Burial | 8-23-60 | Arlington Natl. Cem. | Arlington, Virginia |

| 23. FUNERAL DIRECTOR ADDRESS | 24a. REC'D BY REGISTRAR DATE | 24b. REGISTRAR'S SIGNATURE |
|---|---|---|
| W.W. Chambers Co. 517-11th St. S.E. | AUG 24 '60 | Arthur S. Hurd |

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# 9472 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 2 FilmG2/1 9-15-60 et

09464 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Prince Geo MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY
c. LENGTH OF STAY IN 1b DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Geo General

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE Maryland b. COUNTY Pri. Geo.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 66 Riverdale
d. STREET ADDRESS 6324 - 61st Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First MARTIN Middle P Last Hughes

4. DATE OF DEATH Month Aug Day 30 Year 1960

5. SEX M

6. COLOR OR RACE W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH Feb 18 1879

9. AGE (In years last birthday) 81 yrs.

IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired PRINTER

10b. KIND OF BUSINESS OR INDUSTRY GOVERNMENT

11. BIRTHPLACE (State or foreign country) BALTIMORE MD USA

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. NO

17. INFORMANT CATHERINE C Hughes Address 6324-61 St Riverdale Md

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Accident (Cerebral — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b) Blood Vessel Rupture) — smat

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 443X

DUE TO (c) Hypertensive Cardio Vascular disease — 5 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. No

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I taak charge af the remains described abave, held an Autapsy ☐, Inspectian ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE Dayton O Watkins M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type) DAYTON O WATKINS

DATE SIGNED 8-31-60

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF Sept 3, 1960

22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery

22d. LOCATION (City, town, or county) Bladensburg, Md (State)

23. FUNERAL DIRECTOR'S SIGNATURE Wm. Chambers-Geo ADDRESS Riverdale Md

24a. REC'D BY REGISTRAR DATE SEP 2 '60

24b. REGISTRAR'S SIGNATURE Arthur S. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 9473 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09465

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: D. O. A.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anarundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): East Port Annapolis 0210.2
d. STREET ADDRESS: 323 First Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Irvin — Middle: Gordon — Last: Hutchison

4. DATE OF DEATH: Month: August — Day: 12 — Year: 19 60

5. SEX: M le

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 23, 1918

9. AGE (In years last birthdey): 42 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter

10b. KIND OF BUSINESS OR INDUSTRY: Dept. Agriculture

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: James Hutchison

14. MOTHER'S MAIDEN NAME: Ethel Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes (If yes give war or dates of service): WWII

16. SOCIAL SECURITY NO.: 223-28-9254

17. INFORMANT — Address: Mrs Beverly Hutchison, same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hemorrhage and shook — INTERVAL BETWEEN ONSET AND DEATH

901.6

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Compound fracture of the skull, fracture
DUE TO (c): of both tibias and fibulas, fracture of right radius and ulner

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(c)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Fell about 40 feet from a ladder

20c. TIME OF INJURY: 9:00 a.m. p.m. — Month, Dey, Year: 8/12/60

20d. INJURY OCCURRED While at work ☒ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Building

20f. (City or town) Beltsville (County) P. G. (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James H Boyd M.D.
EXAMINER'S NAME (Type): James I. Boyd
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
DATE SIGNED: 8/12/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: Aug 16th 1960 — 22c. NAME OF CEMETERY OR CREMATORY: ANNAPOLIS NAT. — 22d. LOCATION (City, town, or county): Annapolis — (State): Md

23. FUNERAL DIRECTOR: John M. Snyder Sons. — ADDRESS

24a. REC'D BY REGISTRAR — DATE: AUG 17 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

Prince George's Maryland Married

Beverly D. C. A. East Fork Annapolis

Prince George's General Hospital 323 First Street

Irvin Gordon Hutchison August 12, 60

X Jo White July 23, 1918 42

Painter Dept. Agriculture Virginia U. S. A.

Jonas Hutchison Ethel Jones

Yes WWII 823-23-9258 Mrs Beverly Hutchison, same as # 5

Hemorrhage and shock

Compound fracture of the skull, fracture
of both tibias and fibulas, fracture of right
radius and ulner

Fell about 40 feet from a ladder

9:00 8/12/60 Building Beltsville Md.

James K. Boyd 8/12/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9474

09466

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 6 hrs
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 66 East Riverdale
d. STREET ADDRESS: 5603 Longfellow St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

| 3. NAME OF DECEASED (Type or print) First | Middle | Last | 4. DATE OF DEATH Month | Day | Year |
|---|---|---|---|---|---|
| Baby | Girl | Hynson | Aug | 16 | 1960 |

| 5. SEX | 6. COLOR OR RACE | 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) yrs. | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | | 16 August 1960 | | | | 6 | |

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Cheverly, Md.
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Richard Everett Hynson
14. MOTHER'S MAIDEN NAME: Joyce Ann Carter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mother — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): immaturity
DUE TO
(b): Premature rupture membrane & labor
DUE TO
(c): Incompetant Cervix

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

761.5

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug. 15 1960 to Aug. 15 1960, that (I) (we) last saw the deceased alive on Aug. 15 19 60 and that death occurred at 7,15 P.M. from the causes and on the date stated above.

22a. SIGNATURE: K. Kennedy Skipton M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type): Dr. R. Skipton., M. D.
22d. ADDRESS: 4500 College Ave., College Park, Md.

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 8/17/60 | Mt. Olivet Cemetery | Wash. D.C. |

24. FUNERAL DIRECTOR'S SIGNATURE: Nalley Funeral Home Inc. XVO
ADDRESS: 3200 - R. I. Ave. Mt. Rainier, Md.
25a. REC'D BY REGISTRAR DATE: AUG 18 '60
25b. REGISTRAR'S SIGNATURE: Arthur L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9547 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 09467

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bowie
c. LENGTH OF STAY IN 1b: transient
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): On rt. 197 1½ miles no. rt. 50

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
d. STREET ADDRESS: 909 Seventh Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Martin; Middle: Harrison; Last: Innet

4. DATE OF DEATH: Month: August; Day: 21; Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 19, 1936

9. AGE (In years last birthday): 23 yrs.

IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Officer

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Army

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward Harrison Innet

14. MOTHER'S MAIDEN NAME: Helen Repp

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): currently

16. SOCIAL SECURITY NO.: 088-30-2218

17. INFORMANT: Elsie Hagsey Innet — Address: same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Shock — INTERVAL BETWEEN ONSET AND DEATH:

979X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Universal charring burns of the body

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Locked self in burning car

20c. TIME OF INJURY: 9:30 a.m. (Hour) XX — Month, Day, Year: 8 21 60

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Rt. 197

20f. (City or town): Bowie (County): P.G. (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): James I. Boyd M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 8/21/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal

22b. DATE THEREOF: 8/25/60

22c. NAME OF CEMETERY OR CREMATORY: Maker Funeral Home

22d. LOCATION (City, town, or county) (State): Bennington, Vermont

23. FUNERAL DIRECTOR'S SIGNATURE: Earl B. Watson Funeral Home, Inc — ADDRESS: Belair Rd Baltimore-11, Md

24a. REC'D BY REGISTRAR DATE: AUG 26 '60

24b. REGISTRAR'S SIGNATURE: Clifton S. Knauf

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9516

## CERTIFICATE OF DEATH

09468

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale Md.
c. LENGTH OF STAY IN 1b: 14 hrs.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Eugene Leland Mem. Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Geo
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
d. STREET ADDRESS: 7207 Garland Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Roland — Middle: C. — Last: Jackson

4. DATE OF DEATH: Month: 8 — Day: 31 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☒

8. DATE OF BIRTH: SEPT 9, 1888

9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Railroad Worker

10b. KIND OF BUSINESS OR INDUSTRY: Retired RAILROAD

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Joshua JACKSON

14. MOTHER'S MAIDEN NAME: ELEANOR A. HORNER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.:

17. INFORMANT: Patient's Chart — Address: Leland Mem. Hosp.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 4 hrs
DUE TO (b): C.S.H.D. — grave
DUE TO (c):

Conditions, if ony, which gove rise to immediate couse (a), stoting the underlying couse lost. — I20.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY: Hour o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8-15 1960 to 8-31 1960 that (I) (we) last saw the deceased alive on 8-30 1960 and that death occurred at 25M, from the causes and on the date stated above.

22a. SIGNATURE: Roy B Hartman Jr M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 9/4/60

23c. NAME OF CEMETERY OR CREMATORY: Methodist Church Cem Bivalve, Md.

23d. LOCATION (City, town or county) (State): Bivalve Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: [illegible] & Son ADDRESS: 5732 Georgia Ave NW
W K HUNTEMANN & SON

25a. REC'D BY REGISTRAR DATE: SEP 2 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be [illegible] by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FORM A15 (4) 5M 9/59

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2

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9548 **CERTIFICATE OF DEATH** 09469

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Camp Springs (RURAL)
c. LENGTH OF STAY IN 1b: 3 Hours
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: USAF Hospital Andrews

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Washington 22 DC. (RURAL)
d. STREET ADDRESS: 13701 Swan Harbour Road.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Archie — Middle J. — Last Johnson

4. DATE OF DEATH: Month August — Day 29 — Year 1960

5. SEX: Male

6. COLOR OR RACE: Cauc

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9 Jan 1923

9. AGE (In years last birthday): 37 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): USAF

10b. KIND OF BUSINESS OR INDUSTRY: Air Force Pilot

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Archie Wesley Johnson

14. MOTHER'S MAIDEN NAME: Thelma Walbridge

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): Present

16. SOCIAL SECURITY NO.: 173-14-5018

17. INFORMANT: Records — Address

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Infarct — INTERVAL BETWEEN ONSET AND DEATH: 3 HRS
DUE TO (b): Arterial Sclerotic Heart Disease — 3 hrs
DUE TO (c):

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): PULMONARY EDEMA

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month — Day — Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 28 AUGUST, 1960, to 29 AUGUST, 1960, that I last saw the deceased alive on 29 AUGUST, 1960, and that death occurred at 1:47 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edwin E. Westura M.D. — ADDRESS (Street, city or town, state): USAF HOSPITAL ANDREWS — DATE SIGNED: 29 AUGUST 1960

PHYSICIAN'S NAME (Type): EDWIN E WESTURA CAPT USAF MC — USAF HOSP ANDREWS ANDREWS AFB WASH 25 DC

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/1/60
22c. NAME OF CEMETERY OR CREMATORY: Arlington National Cem.
22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: M. J. Rinaldi — ADDRESS: Rinaldi Funeral Home, Inc. 816 H St., NE, Wash. 2, D. C.

24a. REC'D BY REGISTRAR DATE: AUG 31 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9475

## CERTIFICATE OF DEATH

09470

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 13 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince George General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ritchie
d. STREET ADDRESS: 6501 Darcey Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: George — Middle: — Last: Johnson

4. DATE OF DEATH: Month: Aug. — Day: 22 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: April 1879

9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Johnson

14. MOTHER'S MAIDEN NAME: Serena Howard

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Maggie Iverson-Sis. — Address: 1226 G Street, N.E. D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Malnutrition
DUE TO (b): Generalized Arteriosclerosis
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

450.0

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug. 9 1960 to Aug. 22 1960, that (I) (we) last saw the deceased alive on Aug. 22 1960, and that death occurred at 11:30A.M., from the causes and on the date stated above.

22a. SIGNATURE: William D Rosson M.D., M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☑

22b. DATE SIGNED: 8/23/60

22c. PHYSICIAN'S NAME (Type): WILLIAM D. ROSSON M.D

22d. ADDRESS: 5304 ANNAPOLIS ROAD BLADENSBURG, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/26/60

23c. NAME OF CEMETERY OR CREMATORY: Carroll Chapel

23d. LOCATION (City, town, or county) (State): Mitchellville, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Edward L. Stewart — ADDRESS: 30 H Street, N.E. D.C.

25a. REC'D BY REGISTRAR — DATE: AUG 25 '60

25b. REGISTRAR'S SIGNATURE: C. Edward L. Kramer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9549

## CERTIFICATE OF DEATH

09471
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bradbury Hghts
c. LENGTH OF STAY IN 1b: 13 yrs.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 4809--V--St., S.E.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Pr. Geo.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bradbury Hghts
d. STREET ADDRESS: 4809--V--St., S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JUDITH — Middle E. — Last JOHNSON

4. DATE OF DEATH: Month August — Day 6th — Year 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 2, 1894
9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: --
11. BIRTHPLACE (State or foreign country): Pa.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Andrew Gustof
14. MOTHER'S MAIDEN NAME: Edla K. Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): --
(If yes, give war or dates of service): --
16. SOCIAL SECURITY NO.: --
INFORMANT: Janet M. Johnson — Address: 4809--V-- St., S. E.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CEREBRAL METASTASIS 2°
DUE TO (b): ADENOCARCINOMA of KIDNEY
DUE TO (c):
Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: (a) 4 days; (b) 3 years; (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): CACHEXIA 2° to B & GENERAL METASTASIS

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from —, 1956, to Aug. 6, 1960, that I last saw the deceased alive on 8/6, 1960, and that death occurred at 11:05 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas F. Cullen, M.D. — ADDRESS (Street, city or town, state): 4400 Bowen Rd., SE Wash. DC — DATE SIGNED: 8-7-60

PHYSICIAN'S NAME (Type): Thomas F. Cullen — 4400 Bowen Rd., SE Wash. DC

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug. 9, 1960
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
22d. LOCATION (City, town, or county) (State): Suitland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Simmons Bros — ADDRESS: 1661--Good Hope Rd., SE Washington 20 DC
24a. REC'D BY REGISTRAR DATE: AUG 9 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9550 **CERTIFICATE OF DEATH** Reg. Dist. No. 09472

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BRANDYWINE-RURAL
c. LENGTH OF STAY IN 1b: 1½ yrs.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: #4 HARBURY ROAD

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: P. GEO.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X RURAL - BRANDYWINE
d. STREET ADDRESS: #4 HARBURY ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM Middle EDGAR Last KENNEDY

4. DATE OF DEATH: Month AUG Day 27 Year 1960

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: DEC. 2-1882

9. AGE (In years lost birthday): 77 yrs.
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER

10b. KIND OF BUSINESS OR INDUSTRY: FARM

11. BIRTHPLACE (State or foreign country): KANSAS

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: CHARLES A. KENNEDY

14. MOTHER'S MAIDEN NAME: MARGARET ROSS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: NONE

INFORMANT: DAUGHTER — Address: #4 HARBURY RD. BRANDYWINE MD.
MRS. MIRIAM DUDD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ACUTE CONGESTIVE FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 15 MIN.
DUE TO
(b): ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — 3 YRS.
DUE TO
(c): ___

Conditions, if any, which gave rise to immediate couse (a), stoting the underlying couse lost.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): NONE

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.): None

20c. TIME OF INJURY Month, Doy, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg. etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. 1960 to Present 19 60, that I last saw the deceased alive on MARCH 30, 1960, and that death occurred at 7:00 A.M., from the causes and on the date stated above.
NOTE, This certificate signed with permission of Dr. Watkins
ADDRESS (Street, city or town, state) Surg M, DATE SIGNED
ACTUAL SIGNATURE: Arthur Shaver Jr. M.D. BRANCH Ave. Clinton, Md. 8/27/60
PHYSICIAN'S NAME (Type): ARTHUR SHAVER JR. MD BRANCH AVE. CLINTON, MD. 8/27/60

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 8-31-60

22c. NAME OF CEMETERY OR CREMATORY: St Vincent DePaul Cem

22d. LOCATION (City, town, or county) (State): Rogers, Arkansas

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: The HUNTT Funeral Home, Waldorf, Md.

24a. REC'D BY REGISTRAR DATE: AUG 30 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9551 Item 14 FilmG269 8-26-60 et

## CERTIFICATE OF DEATH

Reg. Dist. No. 09473

1. PLACE OF DEATH
a. COUNTY PRINCE GEORGES MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-CLINTON
c. LENGTH OF STAY IN 1b 1951
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION RT 1 BOX 360

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY P. GEO.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RURAL - CLINTON
d. STREET ADDRESS RT 1 BOX 360
e. IS RESIDENCE ON A FARM? YES X NO

3. NAME OF DECEASED (Type or print) First JOSEPH Middle SANDERS Lost KING

4. DATE OF DEATH Month AUG. Day 21 Year 1960

5. SEX M

6. COLOR OR RACE W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH JAN. 3- 1889

9. AGE (In years last birthday) 71 yrs.

IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER

10b. KIND OF BUSINESS OR INDUSTRY FARM

11. BIRTHPLACE (State or foreign country) WALDORF-MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME JAMES THOMAS KING

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 220-32-2207

INFORMANT JOSEPH ANDERSON KING-SON Address RT 1 BOX 353 CLINTON, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a) ACUTE PULMONARY EDEMA 1 HR.

422.1

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

DUE TO (b) CHRONIC SEVERE CONGESTIVE HEART FAILURE 8 MOS.

DUE TO (c) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 5 YR.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. NONE

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NONE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) NONE

20c. TIME OF INJURY Hour a.m. p.m. Month, Doy, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from SEPT, 1955 to PRESENT that I last saw the deceased alive on AUG. 20, 1960, and that death occurred at 8:55 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Arthur Shaver Jr. M.D. ADDRESS (Street, city or town, state) BRANCH AVE. Clinton Md. DATE SIGNED 8/24/60

PHYSICIAN'S NAME (Type) ARTHUR SHAVER JR. BRANCH AVE. - CLINTON MD 8/24/60

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 8-24-60

22c. NAME OF CEMETERY OR CREMATORY Cedar Hill

22d. LOCATION (City, town, or county) Suitland (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bro. ADDRESS 1660 Good Hope Rd SE Wash 20 DC

24a. REC'D BY REGISTRAR DATE AUG 23 '60

24b. REGISTRAR'S SIGNATURE Evelyn L. Krauss

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/58

1
FOR STATE HEALTH DEPT.

M

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any ... is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 9476 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09474

**1. PLACE OF DEATH**
a. COUNTY: PRINCE GEORGE'S — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHEVERLY
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): PRINCE GEORGE'S GEN HOSPITAL

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ~~PRINCE GEORGE'S~~ D.C.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON, D.C
d. STREET ADDRESS: 920 F ST. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

47X-3

**3. NAME OF DECEASED** (Type or print): First EDWIN — Middle P. — Last LANGE

**4. DATE OF DEATH**: Month AUG — Day 10 — Year 1960

**5. SEX**: MALE

**6. COLOR OR RACE**: CAUCASIAN

**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☒

**8. DATE OF BIRTH**: AUG 15 1901

**9. AGE** (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): CLERK.

**10b. KIND OF BUSINESS OR INDUSTRY**: PARKSIDE HOTEL

**11. BIRTHPLACE** (State or foreign country): ILLINOIS

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: OSCAR G LANGE

**14. MOTHER'S MAIDEN NAME**: HELEN E HOFFMANN ENDERS

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown) (If yes give wer or dates of service): NO

**16. SOCIAL SECURITY NO.**: YES

**17. INFORMANT**: MRS BARBARA BITTNER — Address 6424 FAIRBANKS ST CARROLLTON, MD.

**18. CAUSE OF DEATH** [Enter only one cause par line for (e), (b), and (c).]

MEDICAL CERTIFICATION

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH

420.1

DUE TO (b): Coronary heart disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☐

**20a. EXTERNAL CAUSE WAS** PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. — Month, Day, Yeer 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James T. Boyd M.D.

EXAMINER'S NAME (Type): JAMES T. BOYD

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑

Address (Street, city, town, or county):

DATE SIGNED: 8/10/60

**22a. BURIAL, CREMATION, REMOVAL** (Specify): burial

**22b. DATE THEREOF**: 8/13/60

**22c. NAME OF CEMETERY OR CREMATORY**: Ft. Lincoln Cemetery

**22d. LOCATION** (City, town, or country) (State): Prince George, Md.

**23. FUNERAL DIRECTOR**: The S.H. Hines Co. — Address: 2901 11th St. N.W. Washington 9, D.C.

**24a. REC'D BY REGISTRAR** DATE: AUG 12 '60

**24b. REGISTRAR'S SIGNATURE**: Arthur L. Krauss

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9552

## CERTIFICATE OF DEATH

09475
Reg. Dist. No.

M

1a. PLACE OF DEATH — a. COUNTY: PRINCE GEORGES — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CAMP SPRINGS (RURAL)

c. LENGTH OF STAY IN 1b:

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: USAF HOSPITAL ANDREWS

050

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: MARYLAND — b. COUNTY: PRINCE GEORGES

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): UPPER MARLBORO

d. STREET ADDRESS: RFD BOX 2552

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SARAH — Middle W/B LUVENIA — Last LAPRADE

4. DATE OF DEATH: Month AUG — Day 10 — Year 1960

5. SEX: FEMALE

6. COLOR OR RACE: NEGROID

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 10, 1960

9. AGE (In years last birthday): — yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours 2 — Min. 30

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NA

10b. KIND OF BUSINESS OR INDUSTRY: NA

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: BENJAMIN F LA PRADE

14. MOTHER'S MAIDEN NAME: MAUDE S. DOCKETT

I

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NA — (If yes, give war or dates of service): NA

16. SOCIAL SECURITY NO.: NONE

INFORMANT: CHART — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): MASSIVE EDEMA

773.5

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 2½ HOURS

2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): PREMATURITY

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour a. m. / p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 0550 10 Aug, 1960, to 0620 10 Aug, 1960, that I last saw the deceased alive on 0630 10 Aug, 1960, and that death occurred at 0820 M, from the causes and an the date stated above.

ACTUAL SIGNATURE: [signature] M.D.

ADDRESS (Street, city or town, state): USAF HOSPITAL ANDREWS

DATE SIGNED: 10 August 60

PHYSICIAN'S NAME (Type): WILLIAM F PETERSON LCOL USAF MC

ANDREWS AIR FORCE BASE WASHINGTON 25 DC

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

22b. DATE THEREOF: 8/11/60

22c. NAME OF CEMETERY OR CREMATORY: D. C. Morgue - Washington D.C.

22d. LOCATION (City, town, or county) (State)

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS

24a. REC'D BY REGISTRAR — DATE: AUG 15 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/SB

2050301XV3

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9442 — Reg. Dist. No. 09477

1. PLACE OF DEATH
a. COUNTY: Pr Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt Rainer
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 3330 Buchanon St.

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Md — b. COUNTY: Pr Geo
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt Rainier
d. STREET ADDRESS: 3330 Buchanan — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): (Lydia) First — LYDIA — Middle — ANN — Last — LESCALLET
4. DATE OF DEATH: Month: Aug — Day: 31 — Year: 1960
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 18 — 1871 (~~1880~~)
9. AGE (In years last birthday): 89 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Simon Peter Eves (~~Peter Evans~~)
14. MOTHER'S MAIDEN NAME: Amanda Hildenbrand

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Frances Spurka — Address: 3330 Buchanan Mt Rainier

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Arterio-sclerotic Heart disease — few hours
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
42.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes mellitus
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH: no
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I taak charge af the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Dayton O Watkins M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): DAYTON O WATKINS
DATE SIGNED: 8-31-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-3-1960
22c. NAME OF CEMETERY OR CREMATORY: Union Chapel Cemetery
22d. LOCATION (City, town, or county) (State): Libertytown, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Robert E Daily Jr — ADDRESS: Frederick, Maryland
24a. REC'D BY REGISTRAR DATE: SEP 6 '60
24b. REGISTRAR'S SIGNATURE: Catherine L Kinna

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5) 5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
# 9477 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 09476

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly Md
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly Manor, Md.
d. STREET ADDRESS: 6316 Kilmer Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Jesse — Middle: Lescallett — Last: Jr
4. DATE OF DEATH: Month: Aug. — Day: 27 — Year: 19 60

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug 12, 1936
9. AGE (In years last birthday): 24 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electronic Technician
10b. KIND OF BUSINESS OR INDUSTRY: John Hopkins Research
11. BIRTHPLACE (State or foreign country): Washington D. C.
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Jesse Lascallett
14. MOTHER'S MAIDEN NAME: Delsie Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — Address: Delsie Lescallett — Cheverly Manor, Maryland.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple internal injuries (Head, Chest, & pelvis) — Pronounced. 30 min later
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Auto Collision, Thrown through Windshield of car
20c. TIME OF INJURY: Hour 11:02 a.m. p.m. — Month, Day, Year: 8/27/60
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Bowie, MD. Street
20f. (City or town): Bowie — (County): PG. — (State): MD.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: William D Rosson M.D.
EXAMINER'S NAME (Type): William D. Rosson
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 8/28/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-30-60
22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln
22d. LOCATION (City, town, or county) (State): Colmar Manor, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Wm. F. Gasch, 4739 Balto. Ave., Hyattsville
24a. REC'D BY REGISTRAR DATE: AUG 31 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9478 — Items 8,9 Film C272 10-3-60 et — 09478 Reg. Dist. No.

1. PLACE OF DEATH — a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: Md — b. COUNTY: Pr Geo
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale
d. STREET ADDRESS: 5407 TAYLOR
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First STELLA Middle MADELINE Last LICWALD
4. DATE OF DEATH: Month Aug Day 31 Year 1960

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov 7th 1902
9. AGE (In years last birthday): 57 yrs. 3
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: THOMAS F SCRIBNER
14. MOTHER'S MAIDEN NAME: SARA ANN HARDY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: LOUIS LICWALD — Address: 5407 - TAYLOR RI Riverdale Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | Pulmonary Edema (Thrus | |
| DUE TO (b) | Coronary Heart disease | 5 years |
| DUE TO (c) | (Coronary Sclerosis) | |

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. —
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —
20f. (City or town) (County) (State) —

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Dayton O Watkins M.D.
EXAMINER'S NAME (Type): DAYTON O WATKINS
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 8-31-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-3-60
22c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cem.
22d. LOCATION (City, town, or county) (State): Washington, D. C.

23. FUNERAL DIRECTOR'S SIGNATURE: Lee F. Funeral Home - Wash. D.C. ADDRESS
24a. REC'D BY REGISTRAR DATE SEP 6 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Hawa

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S)
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# 9479 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09479
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Geo General

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Md — b. COUNTY: Pr Geo
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RIVERDALE
d. STREET ADDRESS: 5420-56 ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): ~~Lewis Earl Lowery~~ First: Lewis Middle: Earl Last: Lowery
4. DATE OF DEATH: Month: Aug — Day: 23 — Year: 1960

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: March 17 1882
9. AGE (If under 1 year last birthday): 78 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Telegraph operator
10b. KIND OF BUSINESS OR INDUSTRY: R.R. western maryland
11. BIRTHPLACE (State or foreign country): Md. Ellerslie
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOHN W LOWERY
14. MOTHER'S MAIDEN NAME: ANNA COX

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 205-10-7854
17. INFORMANT: Mrs Norma Long — Address: 5420 56 ave Riverdale Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Surgical Shock | inst |
| DUE TO (b) | Wounds multiplicis & Severe | inst |
| DUE TO (c) | Lacer of Kidney, Fracture of femur | inst |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Subject hit by a car
20c. TIME OF INJURY: Hour 3 13 a. m. p. m. — Month, Day, Year: 8-23 1960
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Street
20f. (City or town) Riverdale (County) Pr Geo (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Dayton O Watkins M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): DAYTON O. WATKINS
DATE SIGNED: 8-23-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/26/60
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: John J. Hofer Cumberland Md
24a. REC'D BY REGISTRAR DATE: AUG 29 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Trone

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 9517 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09480

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

1. PLACE OF DEATH
   a. COUNTY: Prince George's — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XXX Riverdale
   c. LENGTH OF STAY IN 1b: Dead on arrival
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Leland Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Prince George's
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
   d. STREET ADDRESS: 211 Main Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert — Middle: Irving — Last: MacCord

4. DATE OF DEATH: Month: August — Day: 13 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 10, 1914

9. AGE (In years last birthday): 46 yrs.

IF UNDER 1 YEAR: Months ___ Days ___

IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook

10b. KIND OF BUSINESS OR INDUSTRY: Restaurant

11. BIRTHPLACE (State or foreign country): District of Columbia

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Robert Irving Mac Cord

14. MOTHER'S MAIDEN NAME: Helen Capron

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 579-10-2117

17. INFORMANT: Robert I. MacCord — 2303 53rd Ave S.E. Bradbury Heights, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Hemorrhage and shock — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b): Fracture of the base of the skull an d sternum

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20e. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Fell from a porch roof

20c. TIME OF INJURY: Hour: 6:00 XX p.m. — Month, Day, Year: 8/13/60

20d. INJURY OCCURRED: While at work ☐ Not While at work ☒

20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Yard of hotel

20f. (City or town): Laurel (County): P. G. (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.

EXAMINER'S NAME (Type): James I. Boyd

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED: 8/14/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-18-1960

22c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery

22d. LOCATION (City, town, or country): Bladensburg (State): Md

23. FUNERAL DIRECTOR: W. W. Chambers Co. — ADDRESS: Riverdale, Md.

24a. REC'D BY REGISTRAR: DATE: AUG 17 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

1

9480

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

09481

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

**1. PLACE OF DEATH**
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 14 Hrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince Georges General

**2. USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hayattsville
d. STREET ADDRESS: 5619 30 th Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

| 3. NAME OF DECEASED (Type or print) First | Middle | Last | 4. DATE OF DEATH Month | Day | Year |
|---|---|---|---|---|---|
| Samuel | M. | Malay | Aug. | 22 | 19 60 |

| 5. SEX | 6. COLOR OR RACE | 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | W. | | 9-24-06 | 53 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Printer | Post Newspaper Co. | Gloucester Co. Va. | US |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Alexander J. Malay | V. Mary ~~Dead~~ Gwynn |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| | | Samuel M. Malay Jr. dbo |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 443X Portum hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 15 hours
DUE TO (b): Hypertens S. RS. Hrt dis. — 1 Year
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

| 20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19 | 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
|---|---|---|---|
| | | | |

21. **I certify** that (I) (this hospital) attended the deceased from ~~Aug~~ Aug. 22 1960, to Aug 22, 1960, that (I) ~~(we)~~ last saw the deceased alive on Aug 22 1960, and that death occurred at 8:25 pm from the causes and on the date stated above.

| 22a. SIGNATURE | M.D. | ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ | 22b. DATE SIGNED |
|---|---|---|---|
| Henk Levitsky | | | 8/23/60 |

| 22c. PHYSICIAN'S NAME (Type) | 22d. ADDRESS |
|---|---|
| Henk. Levitsky | 3408 Rhode Island AVE Mt. Rainier Md |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 8/26/60 | Fort Lincoln | Colmar Manor Md. |

| 24. FUNERAL DIRECTOR'S SIGNATURE | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Malley's Funeral Home, Inc. | Mt. Rainier, Md. | AUG 29 '60 | Arthur S. Krause |

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9481 — 09482 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Pr Geo — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 2 hrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Prince Geo General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: VA
b. COUNTY: Fluvanna
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CLINCH CO VA.
d. STREET ADDRESS: R 3 X 3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES — Middle ARVIN — Last MARSHALL
4. DATE OF DEATH: Month August — Day 23 — Year 1960
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb 7-1934
9. AGE (In years last birthday): 26 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Coal Miner
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Tennessee
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Marshall
14. MOTHER'S MAIDEN NAME: Susie Bartley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT: Bobby Marshall — Address: Clinchco Va

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a): SURGICAL SHOCK
DUE TO (b): FRACTURE SKULL — 1 hr
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

816 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Automobile accident - MV
20c. TIME OF INJURY: Hour 12 a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway
20f. (City or town) Bowie — (County) Pr Geo — (State) md

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE OF M.D.: Dayton Watkins — DATE SIGNED
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): DAYTON WATKINS

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 8/24/60
22c. NAME OF CEMETERY OR CREMATORY: Colley Funeral Home
22d. LOCATION (City, town, or county): Clintwood — (State) Va

23. FUNERAL DIRECTOR'S SIGNATURE: F Gasch Sons — ADDRESS: Hyattsville, Md
24a. REC'D BY REGISTRAR DATE: AUG 26 '60
24b. REGISTRAR'S SIGNATURE: Evelyn L Kruse

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9553

# CERTIFICATE OF DEATH

09483

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be examined by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1. **PLACE OF DEATH**
a. COUNTY: PRINCE GEORGES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CAMP SPRINGS (RURAL)
c. LENGTH OF STAY IN 1b: 45 DAYS
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: USAF HOSPITAL ANDREWS

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: PRINCE GEORGES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CAMP SPRINGS (RURAL)
d. STREET ADDRESS: 6968 ALLENTOWN ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First SANDRA — Middle LYN — Last MARTIN

4. **DATE OF DEATH**: Month AUGUST — Day 22 — Year 1960

5. SEX: FEMALE

6. COLOR OR RACE: CAUCASIAN

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2 OCTOBER 1959

9. AGE (In years lost birthday) yrs.: —
IF UNDER 1 YEAR: Months 10 — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NA

10b. KIND OF BUSINESS OR INDUSTRY: NA

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: LEWIS G MARTIN

14. MOTHER'S MAIDEN NAME: BETTY LOU FARIET

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service): NA

16. SOCIAL SECURITY NO.: NONE

INFORMANT: LEWIS G MARTIN(FATHER) — Address: SAME AS 2

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): BRONCHOPNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: 45 DAYS
DUE TO
491 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I attended the deceased from 21 August, 19 60, to 21 August, 19 60 that I last saw the deceased alive on 21 AUGUST, 19 60, and that death occurred at 11:45 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Jerome Tilles M.D.
ADDRESS (Street, city or town, state): USAF HOSPITAL ANDREWS
DATE SIGNED: 21 AUGUST 1960

PHYSICIAN'S NAME (Type): JEROME TILLES, CAPT USAF MC
USAF HOSP ANDREWS ANDREWS AFB WASH 25 DC

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 8-25-60
22c. NAME OF CEMETERY OR CREMATORY:
22d. LOCATION (City, town, or county) (State): FREDERICKTOWN OHIO

23. FUNERAL DIRECTOR'S SIGNATURE: RINALDI FUNERAL HOME
ADDRESS: 816 - H St. N.E. DC

24a. REC'D BY REGISTRAR DATE: AUG 24 '60
24b. REGISTRAR'S SIGNATURE: Collins E Keene

205025 3XV3

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9554

## CERTIFICATE OF DEATH

Reg. Dist. No. 09484

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CAMP SPRINGS (RURAL)
c. LENGTH OF STAY IN 1b: 2 DAYS
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: USAF HOSP ANDREWS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: PRINCE GEORGES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANDREWS AFB
d. STREET ADDRESS: MOQ 1-66-2 COLUMBUS CIRCLE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM — Middle S — Lost MILLER JR

4. DATE OF DEATH: Month AUGUST — Day 5 — Year 1960

5. SEX: MALE

6. COLOR OR RACE: CAU

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 28 DECEMBER 1959

9. AGE (In years lost birthday): — yrs. IF UNDER 1 YEAR: Months 7 Days 8 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY: NA

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USAF

13. FATHER'S NAME: WILLIAM S MILLER SQ

14. MOTHER'S MAIDEN NAME: ANNELLE NORTH

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

INFORMANT: HOSPITAL RECORDS — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): PNEUMONIA
DUE TO (b):
DUE TO (c):
Conditions, if any, which gove rise to immediate couse (a), stating the underlying couse lost.

4-93X

INTERVAL BETWEEN ONSET AND DEATH: 48 HRS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3 AUGUST, 1960, to 5 AUGUST, 1960 that I last saw the deceased alive on 5 AUGUST, 1960, and that death accurred at 1110AM, fram the causes and an the date stated abave.

ACTUAL SIGNATURE: John A Moore M.D. — ADDRESS (Street, city or town, state): USAF HOSPITAL ANDREWS — DATE SIGNED: 5 AUGUST 1960

PHYSICIAN'S NAME (Type): JOHN A MOORE CAPT USAF MC — USAF HOSP ANDREWS ANDREWS AFB WASH 25 DC

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 22b. DATE THEREOF: AUG 8-1960. — 22c. NAME OF CEMETERY OR CREMATORY: U.S.N.A. — 22d. LOCATION (City, town, or county) (State): Annapolis, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Sunalde Funeral Home 816-H St NE Wash D.C.

24a. REC'D BY REGISTRAR — DATE: AUG 9 '60 — 24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

2050293XVS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9518 09485

1. **PLACE OF DEATH**
a. COUNTY Prince George MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale
c. LENGTH OF STAY IN 1b 27 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Leland Memorial Hosp

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince Geo
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville
d. STREET ADDRESS 4227 Madison Hyattsville
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print) First Nettie Middle Last Moxley

4. **DATE OF DEATH** Month August Day 29 Year 1960

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 5-14-'85
9. AGE (In years last birthday) 75 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME John Solumbus Rowe
14. MOTHER'S MAIDEN NAME Unk.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 220-12-2686
17. **INFORMANT** Address Hospital Record

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 2 weeks
DUE TO (b) General arteriosclerosis — undetermined
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Hypertension — 10 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from Aug 1 1960 to Aug 29 1960 that (I) (we) last saw the deceased alive on Aug 29 1960, and that death occurred at 4:35 P.M., from the causes and on the date stated above.

22a. SIGNATURE L W Malin M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED 8-29-60
22c. PHYSICIAN'S NAME (Type) L W Malin MD
22d. ADDRESS Riverdale, Md

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 9/1/60
23c. NAME OF CEMETERY OR CREMATORY Epheais
23d. LOCATION (City, town, or county) Foneswood, (State) Va.

24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons
ADDRESS Hyattsville, Maryland
25a. REC'D BY REGISTRAR DATE SEP 1 '60
25b. REGISTRAR'S SIGNATURE Arthur S. Krauss

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

M

I

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

9482

09486
Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4 may be signed by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

**1. PLACE OF DEATH**
a. COUNTY: PRINCE GEORGE'S — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHEVERLY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PRINCE GEORGE'S GEN HOSPITAL

**2. USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: PRINCE GEORGES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): COTTAGE CITY
d. STREET ADDRESS: 3712 BLADENSBURG RD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

077

44

**3. NAME OF DECEASED** (Type or print): First HANNAH — Middle C. — Last MURPHY

**4. DATE OF DEATH**: Month AUG — Day 24 — Year 1960

**5. SEX**: FEMALE

**6. COLOR OR RACE**: CAUCASIAN

**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

**8. DATE OF BIRTH**: JAN 19 1869

**9. AGE** (In years last birthday): 91 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): HOUSEWIFE RETIRED

**10b. KIND OF BUSINESS OR INDUSTRY**:

**11. BIRTHPLACE** (State or foreign country): NEW YORK

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: JOHN SCHNEIDER

**14. MOTHER'S MAIDEN NAME**: UNKNOWN

**15. WAS DECEASED EVER IN U. S. ARMED FORCES?** (Yes, no, or unknown): NO
(If yes, give war or dates of service):

**16. SOCIAL SECURITY NO.**: NONE

**17. INFORMANT**: JOHN A. SMITH — Address: 6105 QUEENS CHAPEL RD HYATTSVILLE, MARYLAND

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): SUB ARACHNOID CVA — INTERVAL BETWEEN ONSET AND DEATH: IMMED

330A

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): HYPERTENSIVE CRISIS — 5 hrs

DUE TO (c): SENILE SCLEROSIS generalized

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☐

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)**

**20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Month, Day, Year — Hour a. m. / p. m. — 19

**20d. INJURY OCCURRED** While at work ☐ Not while at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that I attended the deceased from Aug 22, 1960, to Aug 24, 1960, that I last saw the deceased alive on Aug 24, 1960, and that death occurred at 3 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Benjamin S. Miller M.D. — ADDRESS (Street, city or town, state): 3824-34 AT Mt Rainier — DATE SIGNED: 8/29/60

PHYSICIAN'S NAME (Type): BENJAMIN S. MILLER

**22a. BURIAL, CREMATION, REMOVAL** (Specify): BURIAL
**22b. DATE THEREOF**: AUG 27, 1960
**22c. NAME OF CEMETERY OR CREMATORY**: GLENWOOD CEMETERY
**22d. LOCATION** (City, town, or county) (State): WASHINGTON, D.C.

**23. FUNERAL DIRECTOR'S SIGNATURE**: W.W. Chambers Co. — ADDRESS: RIVERDALE, MD

**24a. REC'D BY REGISTRAR** DATE: AUG 30 '60

**24b. REGISTRAR'S SIGNATURE**: Arthur S. Krauss

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9555

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09487

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Camp Springs
c. LENGTH OF STAY IN 1b: week
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 7150 Brinkley Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Camp Springs
d. STREET ADDRESS: 5210 Middleton Ln
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Magdalen — Last: Murphy

4. DATE OF DEATH: Month: Aug — Day: 9 — Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Jan 15, 1881

9. AGE (In years last birthday): 79 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seamstress

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Govt

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Zephania Wade

14. MOTHER'S MAIDEN NAME: Esther Frances Tredd

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Jane Walter — Address: same as #1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH:
420.0
DUE TO (b): Arteriosclerotic heart disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: James I. Boyd M.D.
EXAMINER'S NAME (Type): JAMES I. BOYD
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: August 9, 1960

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-12-60
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
22d. LOCATION (City, town, or county) (State): Suitland Md

23. FUNERAL DIRECTOR'S SIGNATURE: Simmons Bro.
ADDRESS: 1661 - Good Hope Rd SE Wash. 20 DC

24a. REC'D BY REGISTRAR DATE: AUG 11 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Kines

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

# CERTIFICATE OF DEATH

9436 09488

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
c. LENGTH OF STAY IN 1b: 14 approx. mo.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Carroll Manor

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Falls Church 83X-3
d. STREET ADDRESS: 902 Lincoln Ave,
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First Regina Middle Last Myers

4. DATE OF DEATH: Month August Day 14 Year 1960

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: 2-10-'78
9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): St.Boniface,Penn.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Anthony Anstead
14. MOTHER'S MAIDEN NAME: Catherine Noel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Sr. M.FrancisPatricia Address: 4922 LaSalle Rd. Hyattsville, Md

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARCINOMATOSIS — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO
(b): CARCINOMA OVARY — 1938
DUE TO
(c):

175.0

Conditions, if ony, which gove rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify thot (I) (~~this hospital~~) attended the deceosed from 12 Aug 1960 to 14 Aug 1960, thot (I) (we) lost saw the deceased alive on 14 Aug 1960, ond thot death occurred ot 11:01 A.M., from the causes ond on the date stated above.

22a. SIGNATURE: W. Howard Yeager Jr. M.D.
ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 14 Aug 60.
22c. PHYSICIAN'S NAME (Type): W. HOWARD YEAGER, JR. M.D.
22d. ADDRESS: 1800 CONN AVE N.W. WASH. D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Aug. 17th, 1960
23c. NAME OF CEMETERY OR CREMATORY: Northside Catholic
23d. LOCATION (City, town, or county) (State): Pittsburgh, Penna.

24. FUNERAL DIRECTOR'S SIGNATURE: Robert J. Murphy
ADDRESS: 3524 Columbia Pike Arlington, Va.
25a. REC'D BY REGISTRAR DATE: AUG 17 '60
25b. REGISTRAR'S SIGNATURE: Clifton S. Hume

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

# CERTIFICATE OF DEATH

9483 09489

1

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

**1. PLACE OF DEATH** — a. COUNTY: PRINCE GEORGE — MARYLAND; b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHEVERLY; c. LENGTH OF STAY IN 1b:

**2. USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission) — a. STATE: MARYLAND; b. COUNTY: PRINCE GEORGE'S; c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): E. RIVERDALE

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PRINCE GEORGES GEN. Hospital

d. STREET ADDRESS: 5515 Nicholson St.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

**3. NAME OF DECEASED** (Type or print): First: Robert; Middle: J.; Last: Needham

**4. DATE OF DEATH**: Month: August; Day: 18; Year: 1960

**5. SEX**: Male

**6. COLOR OR RACE**: W

**7.** MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

**8. DATE OF BIRTH**: Jan 13, 1931

**9. AGE** (If years lost birthday): 29 yrs.

IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Asbestos Worker

**10b. KIND OF BUSINESS OR INDUSTRY**:

**11. BIRTHPLACE** (State or foreign country): Washington, D. C

**12. CITIZEN OF WHAT COUNTRY?**: U. S. A

**13. FATHER'S NAME**: Robert J. Needham, Sr.

**14. MOTHER'S MAIDEN NAME**: Rosa R. Matthews

**15. WAS DECEASED EVER IN U. S. ARMED FORCES?** (Yes, no, or unknown): yes (If yes, give war or dates of service): Korean

**16. SOCIAL SECURITY NO.**: yes

**17. INFORMANT**: Rosa R. M. Needham — Address: 5515 Nicholson St Riverdale Md.

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): INFARCTION of R. INTERNAL CAPSULE — INTERVAL BETWEEN ONSET AND DEATH: 3 days

332 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): PRIMARY THROMBOSIS of R INTERNAL CAROTID

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

MEDICAL CERTIFICATION

**20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)**

**20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Month, Day, Year: Hour o. m. p. m. 19

**20d. INJURY OCCURRED** While at work ☐ Not while at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from 8/1/60 19 , to 8/18/ 19 60, that (I) (we) last saw the deceased alive on 8/17/ 19 60 and that death occurred at M, from the causes and on the date stated above.

**22a. SIGNATURE**: Albert Roth M.D. — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED**

**22c. PHYSICIAN'S NAME** (Type): ALBERT ROTH

**22d. ADDRESS**: 3510 Madison St. Riverdale, Md

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF**: 8-22-1960

**23c. NAME OF CEMETERY OR CREMATORY**: Gate of Heaven Cem

**23d. LOCATION** (City, town, or county) (State): Wheaton, Maryland

**24. FUNERAL DIRECTOR'S SIGNATURE**: W. W. Chambers Co — **ADDRESS**: Riverdale, Md.

**25a. REC'D BY REGISTRAR** DATE: AUG 24 '60

**25b. REGISTRAR'S SIGNATURE**:

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9484 · **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 09490

Reg. Dist. No.

1. PLACE OF DEATH — a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George General Hosp.

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 4515 Buchanan Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elmer — Middle: Albaugh — Last: Norris
4. DATE OF DEATH: Month: Aug — Day: 28 — Year: 19 60
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 28 Mar 1888
9. AGE (In years on last birthday): 72 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Guard
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Govt.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry J. Norris
14. MOTHER'S MAIDEN NAME: Mary M. Albaugh

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown): Yes (If yes, give war or dates of service): WWI
16. SOCIAL SECURITY NO.: Unk.
17. INFORMANT: Ottilie L. Norris (Wife) Address: Same as # 2

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: ?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic Cardiovascular disease — ?
DUE TO (c):

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and find that death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: William D. Rosson, M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☑
EXAMINER'S NAME (Type): William D, Rosson
DATE SIGNED: 8/28/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/31/60
22c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln
22d. LOCATION (City, town, or county): Colmar Manor (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: F. Gasch's Sons — ADDRESS: Hyattsville, Maryland
24a. REC'D BY REGISTRAR — DATE: AUG 31 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9507 **CERTIFICATE OF DEATH** Reg. Dist. No. 09491

1. PLACE OF DEATH
a. COUNTY Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colmar Manor
c. LENGTH OF STAY IN 1b 15 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3509 43rd. Avenue

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland — b. COUNTY Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 44 Colmar Manor
d. STREET ADDRESS 3509 - 43 ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Thomas Middle Peter Last O'Neill
4. DATE OF DEATH Month Aug Day 30 Year 1960
5. SEX Male
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 20 June 1870
9. AGE (In years last birthday) 90 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Harness maker
10b. KIND OF BUSINESS OR INDUSTRY Leather
11. BIRTHPLACE (State or foreign country) Dublin Ireland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME John O'Neill
14. MOTHER'S MAIDEN NAME Bridget Reardon
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 011-18-3190
INFORMANT James F. O'Neill Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Senile myocarditis and
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) insufficiency 1. generalized 5 days.
DUE TO
(c) arteriosclerosis
INTERVAL BETWEEN ONSET AND DEATH
422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Totally blind 10 years
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from _____, 19 54, to 30 aug, 19 60 that I last saw the deceased alive on 27 Aug, 19 60, and that death occurred at 6 a.m., from the causes and on the date stated above.

ACTUAL SIGNATURE Thomas E. Mattingly M.D. M.D. — ADDRESS (Street, city or town, state) 2200 R. I. ave N.E. — DATE SIGNED 8/30/60
PHYSICIAN'S NAME (Type) Thomas E. Mattingly M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation
22b. DATE THEREOF 8/30/60
22c. NAME OF CEMETERY OR CREMATORY Griffin & Aldridge Funeral Home
22d. LOCATION (City, town, or county) Rome (State) N. Y.

23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons — ADDRESS Hyattsville, Md.
24a. REC'D BY REGISTRAR DATE SEP 1 '60
24b. REGISTRAR'S SIGNATURE Cathryn L. Ko.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospitol or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/5B

1

FOR STATE HEALTH DEPT.

M

I

2

2

**TO DISPOSITION MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9485

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09494

**1. PLACE OF DEATH**
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 1¼ hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fairmont Heights 30
d. STREET ADDRESS: 5705 Post Street
a. IS RESIDENCE ON A FARM? YES ☐ NO ☑

**3. NAME OF DECEASED** (Type or print): First: Rosella — Middle: Louise — Last: Parker

**4. DATE OF DEATH**: Month: Aug — Day: 8 — Year: 1960

**5. SEX**: Female

**6. COLOR OR RACE**: Colored

**7. MARRIED** ☑ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: June 14, 1926

**9. AGE** (In years last birthday): 34 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housewife

**10b. KIND OF BUSINESS OR INDUSTRY**: Own Home

**11. BIRTHPLACE** (State or foreign country): Virginia

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Robert Edward Spencer

**14. MOTHER'S MAIDEN NAME**: Mary Banks

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): No
(If yes give wer or dates of service)

**16. SOCIAL SECURITY NO.**

**17. INFORMANT**: John W Parker — Address: same as # 2

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | 443X Intra Cranial Hemorrhage | |
| DUE TO (b) | Hypertensive heart disease | |
| DUE TO (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

**19. WAS AUTOPSY PERFORMED?** YES ☑ NO ☐

MEDICAL CERTIFICATION

**20a. EXTERNAL CAUSE WAS** PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of Injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. — Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21.** I **certify** that I took charge of the remains described above, held an Autopsy ☑, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I Boyd M.D.

EXAMINER'S NAME (Type): JAMES I. BOYD

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑

Address (Street, city, town, or county)

DATE SIGNED: 8-9-60

**22a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**22b. DATE THEREOF**: 8/16/60

**22c. NAME OF CEMETERY OR CREMATORY**: Arlington Nat'l. Cem.

**22d. LOCATION** (City, town, or country) (State): Arlington, Va.

**23. FUNERAL DIRECTOR**: Robinson Funeral Chapel

ADDRESS: 1820 9th St., Washington, D.C.

**24a. REC'D BY REGISTRAR** DATE: AUG 12 '60

**24b. REGISTRAR'S SIGNATURE**: Arthur L. Kraus

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9486 09492

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly Md.
c. LENGTH OF STAY IN 1b: 1½mo.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Prince George's General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: W. Va.
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Spencer City
85X-3
d. STREET ADDRESS: 447 Main St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

077

3. NAME OF DECEASED (Type or print): First Zella — Middle Oscar — Last Parks

4. DATE OF DEATH: Month August — Day 15 — Year 1960

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6-23-91
9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY: Hope Nat, Gas. Co
11. BIRTHPLACE (State or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Daniel Parks
14. MOTHER'S MAIDEN NAME: Sarah Jane Cline

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 236 10 4850
17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIAC ARRHYTHMIA — INTERVAL BETWEEN ONSET AND DEATH
420.0
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO (b): ACUTE MYOCARDIAL INFARCTION — 49 Days
DUE TO (c): ARTERIOSCLEROTIC HEART DISEASE.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6-28 1960 to 8-15 1960 that (I) (we) last saw the deceased alive on 8-15 1960 and that death occurred 10:10 pm from the causes and on the date stated above.

22a. SIGNATURE: H. David Kerr, M.D. — M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8-16-60
22c. PHYSICIAN'S NAME (Type): Dr. Kerr., M.D.
22d. ADDRESS: 9812 49th Ave. College Park, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/19/1960
23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial
23d. LOCATION (City, town, or county) (State): Clarksburg, W. Va.

24. FUNERAL DIRECTOR'S SIGNATURE: Lee Funeral Home
ADDRESS: 300 4th St. N. E.
25a. REC'D BY REGISTRAR DATE: AUG 18 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

FOR STATE HEALTH DEPT.

**MARYLAND STATE DEPARTMENT OF HEALTH**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9487 — 09493

**1. PLACE OF DEATH**
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Prince George Gen. Hospital

**2. USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sparrows Point
d. STREET ADDRESS: 7302 Hughes Ave 03X-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Louis — Middle: Fredrick — Last: PAUL Jr.

**4. DATE OF DEATH**: Month: Aug — Day: 19 — Year: 1960

**5. SEX**: Male

**6. COLOR OR RACE**: White

**7. MARRIED** ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: 17 July 1949

**9. AGE** (In years last birthday): 11 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Student

**10b. KIND OF BUSINESS OR INDUSTRY**: School

**11. BIRTHPLACE** (State or foreign country): Maryland

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Louis Fredrick Paul Sr.

**14. MOTHER'S MAIDEN NAME**: Nellie E. Gasser

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown) (If yes give wer or dates of service): No —

**16. SOCIAL SECURITY NO.**: None

**17. INFORMANT** Address: Mrs Nellie Gasser Paul — same as # 2

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hemorrhage and Shock — INTERVAL BETWEEN ONSET AND DEATH
822X
DUE TO (b): Fractured skull.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☐

MEDICAL CERTIFICATION

**20a. EXTERNAL CAUSE WAS** PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of Injury in Part I or Part II of Item 18.): Car overturned on roadway

**20c. TIME OF INJURY** Month, Day, Year: 8 a.m. ☐ p.m. ☐ — 8-18 1960

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☒

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.): Route # 3

**20f.** (City or town) Mitchellville (County) PG. (State) Md.

**21. I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): James I. Boyd

Address (Street, city, town, or county):

DATE SIGNED: 8/19/60

**22a. BURIAL, CREMATION, REMOVAL** (Specify): Burial — **22b. DATE THEREOF**: Aug. 22, 1960 — **22c. NAME OF CEMETERY OR CREMATORY**: Oak Lawn — **22d. LOCATION** (City, town, or country) (State): Colgate, Md.

**23. FUNERAL DIRECTOR** ADDRESS: Ullrich Funeral Home Dundalk, Md.

**24a. REC'D BY REGISTRAR** DATE: AUG 24 '60 — **24b. REGISTRAR'S SIGNATURE**: Arthur S. Kruse

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9488 Items 8,9 Film 6271 9-15-60 et 09495

1. PLACE OF DEATH
a. COUNTY: Prince Georges County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Prince Georges General Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 4100 Quintana Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Margaret; Middle:; Last: Penn

4. DATE OF DEATH: Month: August; Day: 29; Year: 1960

5. SEX: Female

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb 29, 1903

9. AGE (In years last birthday): 57 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Reif

14. MOTHER'S MAIDEN NAME: Margaret Buck

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Harry Webster Penn Address: Hyattsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs
DUE TO
(b): Hypertensive Cardio Vascular Disease 2yrs
DUE TO
(c):

Conditions, if any, which gave rise to immediate couse (a), stoting the underlying couse last.

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify thot (I) (this hospital) ottended the deceased from June 1958 to Aug 29 1960 thot (I) (we) lost sow the deceased alive on Aug 27 1960 ond thot deoth occurred ot 11:45 M, from the causes ond on the date stoted above.

22a. SIGNATURE: Norman Donat Ameau M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8/29/60

22c. PHYSICIAN'S NAME (Type): Norman Donat Ameau
22d. ADDRESS: 3503 Rhode Island Ave. W. Mt Rainier Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/1/60
23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln
23d. LOCATION (City, town, or county) (State): Colmar Manor, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: F. Gasch's Sons ADDRESS: Hyattsville, Maryland

25a. REC'D BY REGISTRAR DATE: SEP 6 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Travis

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

OK by Coroner 8/29/60

VR A15 (4) 1SM 9/59

1

M

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9489

09496

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 5807 44th Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First [redacted]s — Middle John Herman — Last Pickens

4. DATE OF DEATH: Month August — Day 28 — Year 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 10-5-74

9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supervisor Creamery

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Illinois

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: John W. Pickens

14. MOTHER'S MAIDEN NAME: Sarah Adams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: yes

17. INFORMANT: Miss Marion Pickens — Address: SAME AS #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Thrombosis
DUE TO (b): Arteriosclerotic Heart Disease
DUE TO (c): Diabetes Mellitus

260X

Conditions, if ony, which gove rise to immediote couse (a), stoting the underlying couse lost.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Doy, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4-5 19 60 to 8-28 19 60, that (I) (we) last saw the deceased alive on 8-27 19 60 and that death occurred at ____ M, from the causes and on the date stated above.

22a. SIGNATURE: C Deitz M.D.

22b. DATE SIGNED

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): C Deitz M.D.

22d. ADDRESS: 4313 Hallstead St. Hyattsville Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8-30-1960

23c. NAME OF CEMETERY OR CREMATORY: Mount Lincoln Cemetery

23d. LOCATION (City, town, or county) (State): Hadensburg Md

24. FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers Co — ADDRESS: Riverdale, Md

25a. REC'D BY REGISTRAR DATE: AUG 30 '60

25b. REGISTRAR'S SIGNATURE: Clifton S. Krauss

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospitol or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
1SM 9/59

1

FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9430 09497

1. PLACE OF DEATH
a. COUNTY: Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residance before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Dead on arrival
d. STREET ADDRESS: Clinton Daingerfield Drive 12
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Clara; Middle: Illistrious; Last: Plager

4. DATE OF DEATH: Month: August; Day: 2; Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ xx

8. DATE OF BIRTH: June 27, 1884

9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Secretary

10b. KIND OF BUSINESS OR INDUSTRY: Office

11. BIRTHPLACE (State or foreign country): District of Columbia U.S.A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Milton W. Plager

14. MOTHER'S MAIDEN NAME: Sallie Virginia Turner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: 1206 Ingraham N. W.
Alice E. Griffith, Washington, D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute congestive heart failure
DUE TO
(b): Cardiovascular renal disease
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

442 7

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cancer of the colon

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m.; Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER: James I. Boyd M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): James I. Boyd

Address (Street, city, town, or county): August 2, 1960

DATE SIGNED

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Aug 4, 1960

22c. NAME OF CEMETERY OR CREMATORY: Glenwood Cem.

22d. LOCATION (City, town, or country) (State): Washington, D. C.

23. FUNERAL DIRECTOR: W. W. Chamberlain Co.

ADDRESS: Riverdale, Md.

24a. REC'D BY REGISTRAR DATE: AUG 4 '60

24b. REGISTRAR'S SIGNATURE:

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the medical director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Dr. Hilton

Medical Examiner's Certificate of Death

Prince George's Maryland Prince George's

Cheverly Dead on arrival Clinton

Prince George's General Hospital Daingerfield Drive x

Clara Illsterlous Negro August 5, 1860

Female White June 27, 1884 76

Secretary Office District of Columbia U.S.A.

Milton W. Magee Sallie Virginia Turner

No 1206 Thirteen St. N.W.

Alice E. Griffith, Washington, D.C.

None contributive heart failure

Cardiovascular renal disease

Cancer of the colon x

x

x

x

James I. Boyd August 2, 1960

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9556 **CERTIFICATE OF DEATH** 09498 Reg. Dist. No.

1. **PLACE OF DEATH**
a. COUNTY Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Highland Park
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1114-70th Ave

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland — b. COUNTY Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Highland Park
d. STREET ADDRESS 1114-70th Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. **NAME OF DECEASED** (Type or print) First: Annie — Middle: — Last: Plater

4. **DATE OF DEATH** Month: Aug. — Day: 18 — Year: 1960

5. SEX: F

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 11/3/65

9. AGE (In years last birthday): 94 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Daniel Henson

14. MOTHER'S MAIDEN NAME: Jane Stewart

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

INFORMANT: Stewart Henson — Address: Highland Pk. Maryland

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 mos.

DUE TO (b) Cerebral Atherosclerosis — ?

DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerotic Heart Disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I attended the deceased from Dec, 1959, to Aug 18, 1960 that I last saw the deceased alive on Aug 17, 1960, and that death occurred at 11:25 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Wilbur F. Jackson M.D. — ADDRESS (Street, city or town, state) 4649-Deane Av. N.E. — DATE SIGNED 8/18/60

PHYSICIAN'S NAME (Type) Wilbur F. Jackson

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF 8-22-60

22c. NAME OF CEMETERY OR CREMATORY Woodlawn

22d. LOCATION (City, town, or county) Washington DC (State)

23. FUNERAL DIRECTOR'S SIGNATURE Henry D. Washington — ADDRESS 4925 Deane Ave NE

24a. REC'D BY REGISTRAR DATE AUG 22 '60

24b. REGISTRAR'S SIGNATURE Arthur S. Travis

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/5B

1

FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 9491 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09499

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

**1. PLACE OF DEATH**
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chaverly
c. LENGTH OF STAY IN 1b: 8 hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hosp

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Upper Marlboro
d. STREET ADDRESS: Route 301
a. IS RESIDENCE ON A FARM? YES ☐ NO ☑

**3. NAME OF DECEASED** (Type or print): First: Thomas — Middle: Elliott — Last: Proctor

**4. DATE OF DEATH**: Month: August — Day: 19 — Year: 1960

**5. SEX**: Male

**6. COLOR OR RACE**: Colored

**7. MARRIED** ☑ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: Sept 5, 1928

**9. AGE** (In years last birthday): 31 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Truck Driver

**10b. KIND OF BUSINESS OR INDUSTRY**: Hauling

**11. BIRTHPLACE** (State or foreign country): District of Columbia

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Thomas A. Proctor

**14. MOTHER'S MAIDEN NAME**: Alice Randall

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no or unkown): No

**16. SOCIAL SECURITY NO.**: 577-34-9565

**17. INFORMANT**: Elizabeth Hilda Proctor — Address: Same as #7

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cerebral compression — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO (b): Intracranial hemorrhage

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

331X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

**19. WAS AUTOPSY PERFORMED?** YES ☑ NO ☐

MEDICAL CERTIFICATION

**2Da. EXTERNAL CAUSE WAS** PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

**2Db. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. — Month, Day, Year 19

**2Dd. INJURY OCCURRED** While at work ☐ Not While at work ☐

**2Da. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that I took charge of the remains described above, held an Autopsy ☑ Inspection ☑ Inquiry ☑ and in my opinion death resulted from: Natural causes ☑ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.

EXAMINER'S NAME (Type): James I. Boyd

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑

Address (Street, city, town, or county):

DATE SIGNED: 8-19-60

**22a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**22b. DATE THEREOF**: Aug. 22 1960

**22c. NAME OF CEMETERY OR CREMATORY**: Mt. Carmel

**22d. LOCATION** (City, town, or country) (State): Upper Marlboro, Md.

**23. FUNERAL DIRECTOR**: Hunter Funeral Home — ADDRESS: Waldorf, Md.

**24a. REC'D BY REGISTRAR** DATE: AUG 24 '60

**24b. REGISTRAR'S SIGNATURE**: Catherine S. Krug

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9557

## CERTIFICATE OF DEATH

Reg. Dist. No. 09500

1. PLACE OF DEATH
o. COUNTY: PRINCE GEORGES — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE: MARYLAND
b. COUNTY: CHARLES ~~PRINCE GEORGES~~

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (RURAL) - CAMP SPRINGS
c. LENGTH OF STAY IN 1b: ONE HOUR
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (RURAL) - WALDORF Md.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: USAF HOSPITAL ANDREWS
d. STREET ADDRESS: GENERAL DELIVERY
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): ~~Rabasa~~ First: Marie Middle: [illegible] Last: RABASA
4. DATE OF DEATH: Month: August Day: 20 Year: 1960

5. SEX: Female
6. COLOR OR RACE: CAUCASIAN
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 21 AUG 60
9. AGE (In years last birthday) yrs.
IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS.: Hours: 1 | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10b. KIND OF BUSINESS OR INDUSTRY: NONE
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JUAN RABASA
14. MOTHER'S MAIDEN NAME: MINAKO HATTORI

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: NONE
INFORMANT: CHART Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Extreme immaturity
DUE TO (b): Premature birth
DUE TO (c):
Conditions, if ony, which gave rise to immediate couse (o), stating the underlying couse last.

INTERVAL BETWEEN ONSET AND DEATH: One hour

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 21 Aug, 1960, to 21 Aug, 1960, that I last saw the deceased alive on 21 Aug, 1960, and that death occurred at 0249 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: John A. Moore M.D. ADDRESS (Street, city or town, state): USAF HOSP ANDREWS DATE SIGNED: 21AUG60
CAPT USAF MC ANDREWS AFB WASH 25, DC.
PHYSICIAN'S NAME (Type): JOHN A. MOORE USAF HOSP ANDREWS 21AUG60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-23-60
22c. NAME OF CEMETERY OR CREMATORY: St. Peters
22d. LOCATION (City, town, or county) (State): Waldorf Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Hewitt Funeral Home ADDRESS: Waldorf, Md.
24a. REC'D BY REGISTRAR DATE: AUG 24 '60
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

2050242XVO

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# 9519 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09501
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGES MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RIVERDALE
c. LENGTH OF STAY IN 1b: 1 HOUR
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Leland Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LAUREL
d. STREET ADDRESS: 402 CARROLL AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CLINTON Middle Charles Last RECTOR

4. DATE OF DEATH: Month AUG. Day 27 Year 1960

5. SEX: MALE

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MAY 7, 1904

9. AGE (In years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10b. KIND OF BUSINESS OR INDUSTRY: US Govt

11. BIRTHPLACE (State or foreign country): Independence, Va.

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: John Rector

14. MOTHER'S MAIDEN NAME: Flora E. McBride

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Flora E. Rector
Address: Laurel, Md

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CEREBRAL DAMAGE AND Hemmorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 hr
DUE TO (b): PISTOL Shot wound through Cranium — 2 hr
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Self inflicted pistol shot wound

20c. TIME OF INJURY: Hour 3:20 a.m. p.m. Month, Day, Year 8/27/60

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) 402 Carroll St (County) Laurel P.G. (State) MD

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: William D Rosson M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): WILLIAM D. ROSSON, MD
DATE SIGNED: 8/27/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug 30 1960
22c. NAME OF CEMETERY OR CREMATORY: Gulf Hill Cemetery
22d. LOCATION (City, town, or county) (State): Laurel - Prince George - Md

23. FUNERAL DIRECTOR'S SIGNATURE: Beall Funeral Home
ADDRESS: Laurel Md.

24a. REC'D BY REGISTRAR DATE: AUG 31 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Adams

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your [redacted]
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9559 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. 08502

**1. PLACE OF DEATH**
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 3 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Rural

**2. USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
d. STREET ADDRESS: 6611 Phillips Road
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

**3. NAME OF DECEASED** (Type or print): First: Myrtle — Middle: Brown — Last: Regan

**4. DATE OF DEATH**: Month: Aug — Day: 1 — Year: 1960

**5. SEX**: Female

**6. COLOR OR RACE**: White

**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

**8. DATE OF BIRTH**: May 5, 1873

**9. AGE** (In years last Birthday): 87 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housewife

**10b. KIND OF BUSINESS OR INDUSTRY**: Own Home

**11. BIRTHPLACE** (State or foreign country): Virginia

**12. CITIZEN OF WHAT COUNTRY?**: U. S. A.

**13. FATHER'S NAME**: Daniel E Brown

**14. MOTHER'S MAIDEN NAME**: Judith Gowell

**15. WAS DECEASED EVER IN U. S. ARMED FORCES?** (Yes, no, or unknown): No (If yes, give war or dates of service)

**16. SOCIAL SECURITY NO.**:

**17. INFORMANT**: Mrs. Carl Fenwick, Same as #2 — Address:

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Cardiovascular renal disease
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4-42X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senility

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. EXTERNAL CAUSE WAS** PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

**20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour: o. m. / p. m. — Month, Day, Year: 19

**20d. INJURY OCCURRED** While at work ☐ Not while at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21.** I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and find that death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: James T. Boyd M.D.
EXAMINER'S NAME (Type): JAMES T. Boyd

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑

DATE SIGNED: 8-1-60

**22a. BURIAL, CREMATION, REMOVAL** (Specify): Burial
**22b. DATE THEREOF**: 8/3/60
**22c. NAME OF CEMETERY OR CREMATORY**: Cedar Hill
**22d. LOCATION** (City, town, or county) (State): Suitland, Md

**23. FUNERAL DIRECTOR'S SIGNATURE**: Halley's Funeral Home — ADDRESS: Mt. Rainier, Md.

**24a. REC'D BY REGISTRAR** DATE: AUG 5 '60

**24b. REGISTRAR'S SIGNATURE**: Lucian S. Thomas

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9492

09503

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 2 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince George General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 42 Cheverly
d. STREET ADDRESS: 2331 Bellview Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Baby Boy — Middle: — Last: Reilly

4. DATE OF DEATH: Month: Aug. — Day: 19 — Year: 60

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 17, 1960

9. AGE (In years lost birthday) — yrs.
IF UNDER 1 YEAR: Months: — Days: 2
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Gail Patricia Reilly

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mother — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity — INTERVAL BETWEEN ONSET AND DEATH: 2 days.
DUE TO
(b):
DUE TO
(c):

776X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug. 17, 1960, to Aug. 19, 1960, that (I) (we) last saw the deceased alive on Aug. 19 1960, and that death occurred at 1330 A.M. from the causes and on the date stated above.

22a. SIGNATURE: F. E. Musser M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): F. E. Musser

22d. ADDRESS: 4410 74th Ave. Bellmead. Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: 8-24-60

23c. NAME OF CEMETERY OR CREMATORY: Prince George's Gen, Hosp.

23d. LOCATION (City, town, or county) (State): Cheverly, MARYLAND

24. FUNERAL DIRECTOR'S SIGNATURE: Harry W. Penn, Jr.

ADDRESS: Harry W. Penn, Jr. Administrator

25a. REC'D BY REGISTRAR DATE: SEP 7 '60

25b. REGISTRAR'S SIGNATURE: Clifton S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/59

Moves

2077181XV1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# 9493 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 09504

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGE MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHEVERLY
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Pr Geo General, Church rd

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Md
b. COUNTY: Pr Geo
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mount Ranier md
d. STREET ADDRESS: 4410 - 31 ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES Middle BUCHANAN Last RICKS

4. DATE OF DEATH: Month aug Day 23 Year 1960

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: april 13 1897

9. AGE (If over 1 year last birthday): 63 yrs.

IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FOOD CLERK

10b. KIND OF BUSINESS OR INDUSTRY: Grocery

11. BIRTHPLACE (State or foreign country): VIRGINIA

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: CHARLES C RICKS

14. MOTHER'S MAIDEN NAME: ADA SARAH JOHNSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Ye (If yes, give war or dates of service) WW1

16. SOCIAL SECURITY NO. 220-03-4571

17. INFORMANT: CORA RICKS Address 4410 - 31 ST MT RANIER MD

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral accident — INTERVAL BETWEEN ONSET AND DEATH: 1 hour
DUE TO (b): Hypertension
DUE TO (c):

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cirrhosis liver

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): none

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Noturol causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined couse ☐.

ACTUAL SIGNATURE: Dayton Watkins M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 8-22-60

EXAMINER'S NAME (Type): DAYTON O WATKINS

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/25/60
22c. NAME OF CEMETERY OR CREMATORY: Ft Lincoln Cemetery
22d. LOCATION (City, town, or county) (State): Colmar Manor, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: F. Gasch's Sons ADDRESS: Hyattsville, Md

24a. REC'D BY REGISTRAR DATE: AUG 26 '60
24b. REGISTRAR'S SIGNATURE: Clarence L. Knode

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(5)
SM 9/55

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9447 — 09505 — Reg. Dist. No.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

**1. PLACE OF DEATH**
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brentwood
c. LENGTH OF STAY IN 1b: 6 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 3710 Webster Street

**2. USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brentwood
d. STREET ADDRESS: 3710 Webster St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Mary — Middle: Elizabeth — Last: Ryder

**4. DATE OF DEATH**: Month: Aug — Day: 6 — Year: 1960

**5. SEX**: Female

**6. COLOR OR RACE**: White

**7.** MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

**8. DATE OF BIRTH**: Nov 26, 1889

**9. AGE** (In years if over 100 years of birth): 70 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housewife

**10b. KIND OF BUSINESS OR INDUSTRY**: Own Home

**11. BIRTHPLACE** (State or foreign country): Maryland

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: John Bladen

**14. MOTHER'S MAIDEN NAME**: Bridgett Broderick

**15. WAS DECEASED EVER IN U. S. ARMED FORCES?** (Yes, no, or unknown): No — (If yes, give war or dates of service):

**16. SOCIAL SECURITY NO.**: none

**17. INFORMANT**: Gertrude E. Riley, same as #2 — Address:

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebro vascular accident — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO (b): Cardiovascular renal disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

4427

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

**20a.** EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

**20b.** DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

**20c.** TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year: 19

**20d.** INJURY OCCURRED: While at work ☐ Not while at work ☐

**20e.** PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: James D. Boyd M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): JAMES D. BOYD — DATE SIGNED: 8-6-60

**22a.** BURIAL, CREMATION, REMOVAL (Specify): Burial

**22b.** DATE THEREOF: 8/9/60

**22c.** NAME OF CEMETERY OR CREMATORY: Ft Lincoln Cemetery

**22d.** LOCATION (City, town, or county) (State): Colmar Manor, Md.

**23.** FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: F. Gasch's Sons Hyattsville Md.

**24a.** REC'D BY REGISTRAR — DATE: AUG 9 '60

**24b.** REGISTRAR'S SIGNATURE: Arthur S. Kraus

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9494 Item 9 Film G270, 9-6-60 et 09506

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 14 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince Georges Gen Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 4907 — 166th AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Lillian — Middle: E. — Last: Ridgely

4. DATE OF DEATH: Month: August — Day: 27 — Year: 1960

5. SEX: Female

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8-5-1877

9. AGE (In years last birthday): 82 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Domestic

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Nicholas Johnson

14. MOTHER'S MAIDEN NAME: Ella Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Brady H. Ridgley — Address: Same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Renal Failure
DUE TO (b): Arteriosclerosis
DUE TO (c):
446X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Adenocarcinoma of the Colon

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8/13 — 1960, to Aug. 27, 1960 that (I) (we) last saw the deceased alive on August 27 1960, and that death occurred at 3:45 A.M., from the causes and on the date stated above.

22a. SIGNATURE: C. O'Connor, M.D. M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Aug 27-60

22c. PHYSICIAN'S NAME (Type): C. D Connor

22d. ADDRESS: 4410 - 74th ave Bstmd

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: aug 30-60
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
23d. LOCATION (City, town, or county) (State): Suitland Md

24. FUNERAL DIRECTOR'S SIGNATURE: Simmons Bros
ADDRESS: 1661 Good Hope Rd SE
25a. REC'D BY REGISTRAR DATE: AUG 30 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

mail 20 DC

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9437

## CERTIFICATE OF DEATH

Reg. Dist. No. 09507

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGES
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HYATTSVILLE
c. LENGTH OF STAY IN 1b: 2 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: HYATTSVILLE CONVALESCENT + REST HOME
d. STREET ADDRESS: HYATTSVILLE

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE: Md.
b. COUNTY: [redacted] Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HUGHESVILLE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary Middle: Julia Last: Robey

4. DATE OF DEATH: Month: 8 Day: 3 Year: 1960

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1/13/80

9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John E. Dixon

14. MOTHER'S MAIDEN NAME: Mary Rose Montgomery

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 220-34-7957

17. INFORMANT: Raymond Robey
Address: 1052 Buchanan St. N.E

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebro-Vascular Accident
DUE TO (b): cerebral arthrosclerosis
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

331X

INTERVAL BETWEEN ONSET AND DEATH
(a) 48 hr
(b) years
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 7th, 1960, to August 3rd, 1960, that I last saw the deceased alive on August 3rd, 1960, and that death occurred at 8:00 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Till Bergmann M.D.
ADDRESS (Street, city or town, state): 4314 Gallatin St Hyattsville Md.
DATE SIGNED

PHYSICIAN'S NAME (Type): TILL BERGMANN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug. 6 1960
22c. NAME OF CEMETERY OR CREMATORY: St Mary's
22d. LOCATION (City, town or county) (State): Bryantown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Hunter Funeral Home
ADDRESS: Waldorf, Md.

24a. REC'D BY REGISTRAR DATE: AUG 10 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

Hunter Funeral Home - Waldorf, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

C1/32C-5

Mary

Own home Mary Ann

John E Dixon Mary Rose Montgomery

No 220-34-1754

Burial Hagerstown St Mary's Boonsboro Md.

Name of Funeral Home Wade & Md

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9495

Reg. Dist. No. 09508

1. PLACE OF DEATH
a. COUNTY: Pr Geo — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Geo General

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: VA
b. COUNTY: Fluvanna
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CLINTWOOD
d. STREET ADDRESS: RT #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LINDEN Middle C. Lost ROSE, Jr.

4. DATE OF DEATH: Month August Day 23 Year 1960

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept 21 1938

9. AGE (In years last birthday): 21 yrs.

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lab Assistant

10b. KIND OF BUSINESS OR INDUSTRY: Engineering

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: LINDEN CLARENCE ROSE Sr

14. MOTHER'S MAIDEN NAME: Dessie Fleming

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): WW 56-58

16. SOCIAL SECURITY NO.: 226 48 6194

17. INFORMANT: Douglas Rose — Address: 12 a Sunset Dr Alexandria Va

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Wounds multiplicle & Severe — INTERVAL BETWEEN ONSET AND DEATH:

816X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Laceration liver, Laceration — 3 hours
DUE TO (c): Vena Cava - Surgical Shock

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): automobile accident c MV

20c. TIME OF INJURY: Hour 12 03 a. m. p. m. Month, Day, Year 8-23 19 60

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway

20f. (City or town) Bowie (County) Pr Geo (State) md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Dayton Owatkins M.D. — DATE SIGNED

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): DAYTON O WATKINS

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal

22b. DATE THEREOF: 8/24/60

22c. NAME OF CEMETERY OR CREMATORY: Colley Funeral Home

22d. LOCATION (City, town, or county) Clintwood (State) Va

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: F Stasche Sons Hyattsville, Md

24a. REC'D BY REGISTRAR DATE: AUG 26 '60

24b. REGISTRAR'S SIGNATURE: Arthur J. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

9438

09509 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Pro Georges

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md

c. LENGTH OF STAY IN 1b 4 years

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6643 23rd Avenue

d. STREET ADDRESS 6643 23rd avenue

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Robert Middle: Lee Last: Rose

4. DATE OF DEATH Month: Aug Day: 24 Year: 1960

5. SEX male

6. COLOR OR RACE white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH Jan 29, 1900

9. AGE (In years last birthday) 60 yrs.

IF UNDER 1 YEAR Months: Days: IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Building inspector

10b. KIND OF BUSINESS OR INDUSTRY Pro Geo County

11. BIRTHPLACE (State or foreign country) New York

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME Charles Rose

14. MOTHER'S MAIDEN NAME Edith Dates

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

INFORMANT Julia K "ose Address Hyattsville Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carcinoma of Stomach with

DUE TO

(b) metastases involving brain spinal

DUE TO

(c) cord & liver

Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify thot I attended the deceosed from Aug 4, 1960, to Aug 24, 1960, thot I last sow the deceosed alive on Aug 21, 1960, and that death occurred at 6:15 P.M., from the couses ond on the dote stoted above.

ACTUAL SIGNATURE Richard L. Whelton M.D. ADDRESS (Street, city or town, state) 1021 University Blvd E Silver Spring Md DATE SIGNED

PHYSICIAN'S NAME (Type) Richard L Whelton Silver Springs, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation

22b. DATE THEREOF 8/27/60

22c. NAME OF ~~CEMETERY~~ OR CREMATORY Ft Lincoln Crematory

22d. LOCATION (City, town, or county) (State) Colmar Manor Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS F. Gasch's Sons Hyattsville Maryland

24a. REC'D BY REGISTRAR DATE AUG 29 '60

24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be re[illegible] by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

# CERTIFICATE OF DEATH

9496 — 09510

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 1 hr. 10 min
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Landover
d. STREET ADDRESS: 7538 Cleveland Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: Howard — Last: Russell

4. DATE OF DEATH: Month: August — Day: 14 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 3, 1914

9. AGE (In years last birthday): 45 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Emplyd Chaueffer

10b. KIND OF BUSINESS OR INDUSTRY: Airlines Trans. Dompany

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Edward Russell

14. MOTHER'S MAIDEN NAME: Salome Childs

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.: 577-10-5149

17. INFORMANT: Edith A. Russell-Same as above — Address

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Pulmonary Oedima — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Congestive Heart Failure — 6 hours
DUE TO (c): Coronary Insufficiency — 1/2 years

Conditions, if ony, which gove rise to immediate couse (a), stoting the underlying cause lost. 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour o. m. / p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept 19 58, to Aug 14 1960, that (I) (we) last saw the deceased alive on 14 Aug 1960, and that death occurred at ___ M, from the causes and on the date stated above.

22a. SIGNATURE: Thomas M. Sutelius M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 14 Aug 1960

22c. PHYSICIAN'S NAME (Type): Thomas M. Sutelius M.D.
22d. ADDRESS: 7315 Landover Rd. Hyattsville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/18/60
23c. NAME OF CEMETERY OR CREMATORY: Trinity Cemetery
23d. LOCATION (City, town, or county) (State): Upper Marlboro, Md.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Ritchie Bros. Fun'l Home-Upper Marlboro Md.
25a. REC'D BY REGISTRAR DATE: AUG 23 '60
25b. REGISTRAR'S SIGNATURE: Christine L. Krause

**TO HOSPITAL OR ATTENDING PHYSICIAN**: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
**TO FUNERAL DIRECTOR**: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

FOR STATE HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME 5M 7/59

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

94.3.9

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 2 FilmG269 8-18-60 ev

09511

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
c. LENGTH OF STAY IN 1b: 2 week
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Fort Branch Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS (No. and St.): 3120 Powder Mill Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CARL Middle PATRICK Last Savage

4. DATE OF DEATH: Month Aug. Day 9 Year 1960

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-24-1905

9. AGE (In years last birthday): 55 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SALESMAN

10b. KIND OF BUSINESS OR INDUSTRY: MAGAZINE

11. BIRTHPLACE (State or foreign country): ALABAMA

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give year or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: YES — Address: Mr. Christopher Lamoureux, 1015 Chestnut 400 Jefferson Bldg

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Congestive heart failure
DUE TO (b): Cardiovascular renal disease
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: St. Phil., Pa.

442X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. / p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐; and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.

EXAMINER'S NAME (Type): James I. Boyd

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

DATE SIGNED: 8-9-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Aug. 16, 1960

22c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery

22d. LOCATION (City, town, or country) (State): Washington, D. C.

23. FUNERAL DIRECTOR: W. W. CHAMBERS CO. — ADDRESS: Riverdale, Md.

24a. REC'D BY REGISTRAR DATE: AUG 15 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

1

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9497

09512

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1. **PLACE OF DEATH**
   a. COUNTY: Prince Georges County — MARYLAND
   b. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): Cheverly
   c. LENGTH OF STAY IN 1b: 9 days
   d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince Georges General Hospital

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Prince Georges
   c. CITY OR TOWN (If outside carporote limits, write RURAL and give nearest town): Cedar Heights, Md.
   d. STREET ADDRESS: 1100 64th Ave.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First John — Middle — Last Savoy

4. **DATE OF DEATH**: Month August — Day 6 — Year 1960

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11-12-07

9. AGE (In years last birthday): 52 yrs.
   IF UNDER 1 YEAR: Months — Days
   IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lab orer

10b. KIND OF BUSINESS OR INDUSTRY: Metal Finisher

11. BIRTHPLACE (State or foreign country): Chester, Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Savoy

14. MOTHER'S MAIDEN NAME: Minnie Swann

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
   (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 579 12 6781

17. **INFORMANT**: Mary Savoy 1100 64 Ave., Cedar Hgts, Md

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | Hepatic Failure | ? |
| DUE TO (b) | Carcinomatosis | ? |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) | Carcinoma of Pancreas | 6 MONTHS |

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from July 28 1960, to Aug. 6 1960, that (I) (we) last saw the deceased alive an Aug. 6 1960, and that death occurred at 4:45 PM, from the causes and on the date stated above.

22a. SIGNATURE: C. James Duke M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Dr. C. James Duke, M.D.

22d. ADDRESS: 6607 Riverdale Road, Riverdale MdD.

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: 8-10-60

23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet

23d. LOCATION (City, town, or county) (State): Washington, D.C.

24. FUNERAL DIRECTOR'S SIGNATURE: M. K. Rollins
ADDRESS: 4339 Hunt Pl. NE.

25a. REC'D BY REGISTRAR DATE AUG 9 '60

25b. REGISTRAR'S SIGNATURE: Evelyn G. Krauss

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# 9558 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09513

Reg. Dist. No.

Item 4 FilmG273 10-14-60 et

1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine
c. LENGTH OF STAY IN 1b 15 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rt#2 Box 281

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine
d. STREET ADDRESS Route #2 Box 281
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First: Leddy Middle: Balfour Last: Shaw
4. DATE OF DEATH Month: Aug Day: 9, 11 Year: 1960
5. SEX male
6. COLOR OR RACE white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH August 31, 1901
9. AGE (In years last birthday) 58 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Army Officer
10b. KIND OF BUSINESS OR INDUSTRY Retired
11. BIRTHPLACE (State or foreign country) Kansas
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Neff Shaw
14. MOTHER'S MAIDEN NAME Bertha Balfour
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give year or dates of service) 1917 until 1948
16. SOCIAL SECURITY NO. none
17. INFORMANT Address: Mrs Betty Shaw, same as #2

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b) Polycythemia vera

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

294X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE James I Boyd M.D.
EXAMINER'S NAME (Type) JAMES I. BOYD

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED August 10, 1960

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF 8/16/60
22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEM.
22d. LOCATION (City, town, or county) (State) FORT MYER, VIRGINIA

23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawler's Sons
ADDRESS 1756 PA. AVE., N.W. D.C.6

24a. REC'D BY REGISTRAR DATE AUG 12 '60
24b. REGISTRAR'S SIGNATURE Arthur S. Trama

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute [illegible] certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S)
5M 9/55

FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9498

09514

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Belmead
d. STREET ADDRESS: 3906 - 74th Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Walter — Middle: Stanley — Last: Siciak

4. DATE OF DEATH: Month: August — Day: 15 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 20 Nov. 1918

9. AGE (In years last birthday): 41 yrs.

IF UNDER 1 YEAR: Months / Days

IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Industry Agent

10b. KIND OF BUSINESS OR INDUSTRY: Dept. of Justice

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Anthony Siciak

14. MOTHER'S MAIDEN NAME: Tecla Piasecka

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes (If yes give war or dates of service): 1940 - 1946

16. SOCIAL SECURITY NO.: 050-05-4376

17. INFORMANT: Mary B Siciak — Address: same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute congestive heart failure
DUE TO (b): myocardial failure
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

434.1

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I Boyd M.D.

EXAMINER'S NAME (Type): James I. Boyd

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED: 8/16/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Aug 19, 1960

22c. NAME OF CEMETERY ~~OR CREMATORY~~: ARLINGTON NATIONAL

22d. LOCATION (City, town, or country): ARLINGTON (State): Va

23. FUNERAL DIRECTOR: Shaffell — ADDRESS: 4754 N.W. Park Pl.

24a. REC'D BY REGISTRAR — DATE: AUG 18 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

**TO DEATH MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

James I. Boyd

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9520

## CERTIFICATE OF DEATH

Reg. Dist. No. 09515

1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale
c. LENGTH OF STAY IN 1b 11 years
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION 6109 54th avenue

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Pro George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale
d. STREET ADDRESS 6109 54th avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Lois Middle Reese Last Smith
4. DATE OF DEATH Month August Day 11, Year 19 60

5. SEX female
6. COLOR OR RACE white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Feb 17, 1913
9. AGE (In years last birthday) 47 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary A C F
10b. KIND OF BUSINESS OR INDUSTRY Industries
11. BIRTHPLACE (State or foreign country) Iowa
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME Edward Reese
14. MOTHER'S MAIDEN NAME Edith Drushella

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no
16. SOCIAL SECURITY NO.
INFORMANT Address Frank Smith Riverdale, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH 24 hrs
DUE TO (b) Hypertensive cardiovascular
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) disease — years
420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) no
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1953, 19__, to 8-11, 1960, that I last saw the deceased alive on 8-11, 1960, and that death occurred at 10:00 P.M., from the causes and on the date stated above.
ACTUAL SIGNATURE Dayton O Watkins M.D. ADDRESS (Street, city or town, state) 5304 Annapolis Rd DATE SIGNED
PHYSICIAN'S NAME (Type) DAYTON O WATKINS Bladensburg md 8-10-60

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Aug 16, 1960
22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery
22d. LOCATION (City, town, or county) (State) Colmar Manor Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS F. Gasch's Sons Hyattsville Md.
24a. REC'D BY REGISTRAR DATE AUG 19 '60
24b. REGISTRAR'S SIGNATURE Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9510 **CERTIFICATE OF DEATH** Reg. Dist. No. 09516

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Laurel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Burtonsville
d. STREET ADDRESS: 14520 Columbia Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

1515-2

3. NAME OF DECEASED (Type or print): First: Bessie — Middle: I — Last: Soper
4. DATE OF DEATH: Month: August — Day: 5 — Year: 19 60
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 7/15/1871
9. AGE (In years last birthday): 89 yrs.
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: John Ridgely Randolph Carroll
14. MOTHER'S MAIDEN NAME: unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hospital Records — Address:

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

| PART I. DEATH WAS CAUSED BY: | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Bronchopneumonia | 2 days |
| DUE TO (b) | Cerebral Thrombosis | 1 Month |
| DUE TO (c) | Gen - Arteriosclerosis | 15 Yrs - |

J32.X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senility

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5-13, 19 42 to 8/5, 1960, that I last saw the deceased alive on 8/4, 1960, and that death occurred at 5:47 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: J M Warren M.D.
ADDRESS (Street, city or town, state): 305 Prince George Street, Laurel, Maryland
DATE SIGNED:
PHYSICIAN'S NAME (Type): J. M. Warren, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/7/60
22c. NAME OF CEMETERY OR CREMATORY: Christ Church Cem.
22d. LOCATION (City, town, or county) (State): Guilford Md.
23. FUNERAL DIRECTOR'S SIGNATURE: Nellie Pumphrey — ADDRESS: Laurel Md.
24a. REC'D BY REGISTRAR DATE: AUG 9 60
24b. REGISTRAR'S SIGNATURE: Clarence L. Mans

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

M

I

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 9560 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09517

**1. PLACE OF DEATH**
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): West Lanham Hills
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 7710 Annapolis Road

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Seat Pleasant
d. STREET ADDRESS: 7019 F Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Charles — Middle: Edward — Last: Soper

**4. DATE OF DEATH**: August 7th. 1960

**5. SEX**: Male

**6. COLOR OR RACE**: White

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: Jan. 22, 1907

**9. AGE** (In years last birthday): 53 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Truck Driver Help

**10b. KIND OF BUSINESS OR INDUSTRY**: Trucker

**11. BIRTHPLACE** (State or foreign country): Maryland

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Charles E. Soper

**14. MOTHER'S MAIDEN NAME**: Unknown

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown) (If yes give war or defes of service): No

**16. SOCIAL SECURITY NO.**: 579-16-7178

**17. INFORMANT**: Mrs. Jane A. Floyd — Address: 6805 Beacon Pl. Riverdale, Md.

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | Toxemia | |
| 002X DUE TO (b) | Bilateral Lobar Pneumonia | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) | Pulmonary Tuberculosis | |

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

MEDICAL CERTIFICATION

**20a. EXTERNAL CAUSE WAS** PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of Injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. — Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.) — **20f.** (City or town) (County) (State)

**21. I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.

EXAMINER'S NAME (Type): James I. Boyd

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

DATE SIGNED: August 7, 1960

**22a. BURIAL, CREMATION, REMOVAL** (Specify): Burial — **22b. DATE THEREOF**: 8-10-60 — **22c. NAME OF CEMETERY OR CREMATORY**: Washington National — **22d. LOCATION** (City, town, or country) (State): Suitland, Md.

**23. FUNERAL DIRECTOR**: W. W. Chambers Co — ADDRESS: Riverdale, Md.

**24a. REC'D BY REGISTRAR** DATE: AUG 11 '60 — **24b. REGISTRAR'S SIGNATURE**: Arthur L. Krauss

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9561 **CERTIFICATE OF DEATH** 09518

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Prince George MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural
c. LENGTH OF STAY IN 1b 45 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7805 Allentown Rd S.F.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY P. George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) B7805 Allentown Rd S.F.
d. STREET ADDRESS 7805 allentown Rd S.F.
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First Lowe Middle Edelen Last Steed

4. DATE OF DEATH Month August Day 6 Year 1960

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH August 1, 1868
9. AGE (If years last birthday) 92 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY Farmer
11. BIRTHPLACE (State or foreign country) Jackson Missipp.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John J.R. Steed
14. MOTHER'S MAIDEN NAME Mary Pamelia Edelen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. No
17. INFORMANT Helen E. Steed Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(b) Myocardial Degeneration — 10 days
DUE TO
(c) Arterio-Sclerosis r Senility — 3 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8-5-60, 19____, to 8-6-60 19____, that I last saw the deceased alive on 8-5-60, 19____, and that death occurred at 5:30 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE Anna Coyne Todd M.D. ADDRESS (Street, city or town, state) 7519 Broadview Rd S.E. DATE SIGNED

PHYSICIAN'S NAME (Type) Anna Coyne Todd M.D. Wash. 22, D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 8-9-60
22c. NAME OF CEMETERY OR CREMATORY Steed's Private Cemetery
22d. LOCATION (City, town, or county) (State) Allentown Md.

23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bro. ADDRESS 1661 Good Hope Rd SE Wash 20 D.C.
24a. REC'D BY REGISTRAR DATE AUG 9 '60
24b. REGISTRAR'S SIGNATURE Arthur J. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9499 — 09520 — Reg. Dist. No.

1. PLACE OF DEATH — o. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Geo General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — o. STATE: Md — b. COUNTY: Pr Geo
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 3402 Shepherd St
d. STREET ADDRESS: MT RANIER
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MELVA — Middle: LOUISE — Last: Stinnett
4. DATE OF DEATH: Month: Aug — Day: 30 — Year: 1960

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: Oct 5 1918
9. AGE (In years last birthday): 42 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: CHARLES STINNETT
14. MOTHER'S MAIDEN NAME: EUFOLA GOODMAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Violet Seaton — Address: 1902 Van Buren St W. Hyattsville Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute pulmonary congestion
DUE TO (b): Barbiturate? intoxication
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Swallowed a number of Pills
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Dayton O Watkins M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): DAYTON O WATKINS
DATE SIGNED: 8-30 60

22a. BURIAL, CREMATION, REMOVAL (Specify): Buried
22b. DATE THEREOF: 9-1-1960
22c. NAME OF CEMETERY OR CREMATORY: Ft Lincoln Cemetery
22d. LOCATION (City, town, or county) (State): Bladensburg Md

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: W. W. Chambers Co. Riverdale, Md
24a. REC'D BY REGISTRAR DATE: SEP 2 '60
24b. REGISTRAR'S SIGNATURE: Cirilus S. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9562

## CERTIFICATE OF DEATH

09519
Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

| | |
|---|---|
| **1. PLACE OF DEATH** a. COUNTY: PRINCE GEORGES — MARYLAND | **2. USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission) a. STATE: DISTRICT OF COLUMBIA — b. COUNTY |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CAMP SPRINGS (RURAL) — c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON DC |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: USAF HOSPITAL ANDREWS | d. STREET ADDRESS: 134 IRVINGTON ST SW 47X2 — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒ |

| 3. NAME OF DECEASED (Type or print) First | Middle | Last | 4. DATE OF DEATH Month | Day | Year |
|---|---|---|---|---|---|
| DEBORAH | ANN | STICKELL | AUGUST | 9 | 1960 |

| 5. SEX | 6. COLOR OR RACE | 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| FEMALE | CAUCASIAN | | 8 AUGUST 1960 | – yrs. | – | 1 | 24 | 2 |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| NA | NA | MARYLAND | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| EDWARD B STICKELL | JO ANNE B HARVEY |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|---|
| NA | NA | NONE | RECORDS | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY DISEASE OF THE NEWBORN — INTERVAL BETWEEN ONSET AND DEATH: 29 HOURS

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 773.0 — DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

| 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
|---|---|---|---|---|
| 20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19 | 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) (State) |

21. I certify that I attended the deceased from 9 AUGUST, 1960, to 9 AUGUST, 1960, that I last saw the deceased alive on 9 AUGUST, 1960, and that death occurred at 9 55 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: John R. Delahunty M.D. — ADDRESS (Street, city or town, state): ANDREWS A.F.B. HOSPITAL MARYLAND — DATE SIGNED

PHYSICIAN'S NAME (Type): JOHN R DELAHUNTY CAPT USAF MC — ANDREWS AFB WASH 25 DC — 9 AUGUST 60

| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Aug 15, 60 | Arlington National | Arlington Virginia |

| 23. FUNERAL DIRECTOR'S SIGNATURE | ADDRESS | 24a. REC'D BY REGISTRAR DATE | 24b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| W. W. Chambers Co | Riverdale, Md | AUG 15 '60 | Arthur S. Kruse |

2050255XV3

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9521 09521

# CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale
c. LENGTH OF STAY IN 1b 5 hr. 50 min
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Leland Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Pr. Geo.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville
d. STREET ADDRESS 621 Sheridan St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Middle Last Stowe

4. DATE OF DEATH Month 8 Day 19 Year 1960

5. SEX M

6. COLOR OR RACE W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH 8-19-60

9. AGE (In years last birthday) — yrs. IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS. Hours 3 Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —

10b. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Robert S Stowe, Jr.

14. MOTHER'S MAIDEN NAME Eunice ~~Stowe~~ Piptin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT hosp. Address records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 769.5 Prematurity -
DUE TO (b) Forensic of pregnancy of mother with
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH 3 hrs 5 min

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug 19 1960 to ——— 19—, that (I) (we) last saw the deceased alive on Aug 19 1960 and that death occurred at 3:40 P.M., from the causes and on the date stated above.

22a. SIGNATURE L W Mallin M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED 8-19-60

22c. PHYSICIAN'S NAME (Type) L W Mallin MD

22d. ADDRESS Riverdale, Md

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE THEREOF 8/20/60

23c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery

23d. LOCATION (City, town, or county) (State) Bladensburg Md.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS F. Gasch's Sons Hyattsville Md.

25a. REC'D BY REGISTRAR DATE AUG 25 '60

25b. REGISTRAR'S SIGNATURE Clifton S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 1SM 9/59

2076181XVI

1

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

09522

9500

## CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
1SM 9/59

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHEVERLY
c. LENGTH OF STAY IN 1b: 6 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PRINCE GEORGES GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: PRINCE GEORGE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FORESTVILLE
d. STREET ADDRESS: 3423 83rd AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joseph — Middle: HENRY — Last: Talbott

4. DATE OF DEATH: Month: August — Day: 6 — Year: 1960

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: SEPT 2nd, 1887

9. AGE (If years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PAPERHANGER

10b. KIND OF BUSINESS OR INDUSTRY: SELF-EMPLOYED

11. BIRTHPLACE (State or foreign country): WASH. D.C.

12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: UNKNOWN

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or Unknown): NO
(If yes, give war or dates of service): NONE

16. SOCIAL SECURITY NO.: UNKNOWN

17. INFORMANT: DELORES R. COLLINS — Address: 1853 Minnesota Ave S.E. Wash DC

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 8 hours
DUE TO (b): Acute myocardial infarction — 2 weeks
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Aug. 1 1960 to Aug. 6 1960, that (I) (we) last saw the deceased alive on Aug. 6 1960, and that death occurred at 12:35 P.M. due to the causes and on the date stated above.

22a. SIGNATURE: C. James Duke M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Dr. C. James Duke, M.D.

22d. ADDRESS: 6607 Riverdale Road, Riverdale, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 8/15/60
23c. NAME OF CEMETERY OR CREMATORY: WASH. NAT'L CEM.
23d. LOCATION (City, town, or county) (State): SUITLAND-MD 60 Co MD.

24. FUNERAL DIRECTOR'S SIGNATURE: W. W. CHAMBERS CO. — ADDRESS: WASH. D. C.

25a. REC'D BY REGISTRAR — DATE: AUG 11 '60
25b. REGISTRAR'S SIGNATURE: Curtis L. Evans

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9563

## CERTIFICATE OF DEATH

09523
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): W. Hyattsville
c. LENGTH OF STAY IN 1b: four years

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arlington
d. STREET ADDRESS: 3912 - 4th Street North
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Sacred Heart Home

3. NAME OF DECEASED (Type or print): First: Loretta — Middle: D. — Last: Teegarden

4. DATE OF DEATH: Month: August — Day: 3 — Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: April 8, 1883

9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Patrick Bracken

14. MOTHER'S MAIDEN NAME: Anna Flanagan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): unknown
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: Sacred Heart Home, W. Hyattsville, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY THROMBOSIS (a)
DUE TO (b): MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: 36 hrs
DUE TO (c): Hypertensive heart disease — 6 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 7, 19 56 to Aug 3, 19 60 that I last saw the deceased alive on July 27, 19 60, and that death occurred at 8 30 p.m., from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas F Collins M.D.
ADDRESS (Street, city or town, state): 332 - H NE
DATE SIGNED: 8-3-60

PHYSICIAN'S NAME (Type): THOMAS F. COLLINS MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/8/1960
22c. NAME OF CEMETERY OR CREMATORY: XXXXX Arlington National
22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Douglas M Underhill
ADDRESS: 3245 Wilson Blvd. Arlington, Virginia
For Fitzgerald Funeral Home

24a. REC'D BY REGISTRAR — DATE: AUG 5 '60
24b. REGISTRAR'S SIGNATURE: Collins S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to buriol, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

# CERTIFICATE OF DEATH

9501 09524

1. PLACE OF DEATH
a. COUNTY: PrinceGeorge's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Prince George's General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Boulevard Height's
d. STREET ADDRESS: 4809 Ellis St. S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Julius — Middle: George — Last: Teias

4. DATE OF DEATH: Month: August — Day: 2 — Year: 19 60

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8-17-93

9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waiter
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Greece
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Teias
14. MOTHER'S MAIDEN NAME: Celia Pipe

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: John G. Teias — Address: Same as #2 above

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute pul. emp. & Edema — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Arterio sclerotic Heart dis.
DUE TO (c):
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

4200

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7-28 1960, to 8-2 1960, that (I) (we) last saw the deceased alive on 8-2 1960, and that death occurred at 7:10 P.M. from the causes and on the date stated above.

22a. SIGNATURE: C. James Duke — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8/3/60
22c. PHYSICIAN'S NAME (Type): C. James Duke
22d. ADDRESS: 5705 18th Ave Hyattsville, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8-5-1960
23c. NAME OF CEMETERY OR CREMATORY: Washington Nat'l
23d. LOCATION (City, town, or county) (State): Suitland, Md

24. FUNERAL DIRECTOR'S SIGNATURE: R. G. Mattingly — ADDRESS: 131-11th St SE
25a. REC'D BY REGISTRAR — DATE: AUG 4 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospitol or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9502

09525

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince Georges General Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: A. A. ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lothian
d. STREET ADDRESS: 02X-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

077

3. NAME OF DECEASED (Type or print): First Alice — Middle C. — Last Thames

4. DATE OF DEATH: Month August — Day 12 — Year 1960

5. SEX: Female

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 9-28-87

9. AGE (In years last Birthday): 72 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

M

I

13. FATHER'S NAME: Lewis Chaney

14. MOTHER'S MAIDEN NAME: Maria Stallings

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: Mrs. Lou Semel- Upper Marlboro, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | Cerebral Thrombosis | Unreal |
| DUE TO (b) | Embolus from Coronary Infarction | 5 days. |
| DUE TO (c) | Arteriosclerotic Coronary Disease | 10 yrs. |

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 1960, to 15 Aug 1960, that (I) (we) last saw the deceased alive on 15 Aug 1960, and that death occurred at 10:30 A.M., from the causes and on the date stated above.

22a. SIGNATURE: R. B. Sasscer M.D.

ATTENDING PHYS. ✓ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/18/60

22c. PHYSICIAN'S NAME (Type): Robert B. Sasscer, M.D.

22d. ADDRESS: Upper Marlboro, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/21/60

23c. NAME OF CEMETERY OR CREMATORY: Smithville Cemetery

23d. LOCATION (City, town, or county) (State): Smithville, Md.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Ritchie Bros. Funeral Home-Upper Marlboro, Md.

25a. REC'D BY REGISTRAR DATE: AUG 23 '60

25b. REGISTRAR'S SIGNATURE: Arthur L. Krause

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9522

09526

## CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1. **PLACE OF DEATH**
   a. COUNTY: Prince George — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION): DOA Leland Memorial Hospital

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Prince George
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
   d. STREET ADDRESS: 1007 Montgomery Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Melvin — Middle: — Last: Thomas

4. **DATE OF DEATH**: Month: August — Day: 11, — Year: 1960

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: November 3, 1903

9. AGE (In years last birthday): 56 yrs.
   IF UNDER 1 YEAR: Months — Days
   IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck driver

10b. KIND OF BUSINESS OR INDUSTRY: Town of Laurel

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jeremiah Thomas

14. MOTHER'S MAIDEN NAME: Mary Elizabeth Thomas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 214 16 3553

17. **INFORMANT** Address: Mrs. Melvin Thomas, Laurel, Maryland

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Artery Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Immed.
DUE TO (b): Atherosclerosis — 5 yrs
DUE TO (c):

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED White at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 5/2/60 19___, to 8/11 19 60, that (I) (we) last saw the deceased alive on 8/11 19 60, and that death occurred at ___ M, from the causes and on the date stated above.

22a. SIGNATURE: Frank L. Weaver, Jr. M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8/14/60

22c. PHYSICIAN'S NAME (Type): FRANK WEAVER, JR.

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: August 15, 1960

23c. NAME OF CEMETERY OR CREMATORY: Amy Bell Cemetery

23d. LOCATION (City, town, or county) (State): Laurel Md

24. FUNERAL DIRECTOR'S SIGNATURE: DeWitt Donaldson — ADDRESS: Laurel, Md.

25a. REC'D BY REGISTRAR DATE: AUG 17 '60

25b. REGISTRAR'S SIGNATURE: Clifton D. Purnell

1

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9503 09527

M

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): X Clinton
d. STREET ADDRESS: X
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

077

3. NAME OF DECEASED (Type or print): First Eugene — Middle — Last Thompson

4. DATE OF DEATH: Month August — Day 6 — Year 1960

5. SEX: Male
6. COLOR OR RACE: Black
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 31 Oct. 1863
9. AGE (In years last birthday): 96 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Farmer
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Chapman Thompson
14. MOTHER'S MAIDEN NAME: Catherine Proctor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: Francis L. Thompson — Address: Rt. 1, Box 687A, Clinton, Maryland

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).]

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) | Pulmonary Edema | 24 hrs. |
| DUE TO (b) | Carcinoma ? ? | ? |
| DUE TO (c) | Bronchogenic Carcinoma | ? |

162.1

Conditions, if ony, which gove rise to immediate couse (o), stoting the underlying couse lost.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Doy, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug. 4, 1960, to Aug. 6, 1960, that (I) (we) last saw the deceased alive on Aug. 6, 1960, and that death occurred at 12, 15 AM, from the causes and on the date stated above.

22a. SIGNATURE: C. James Duke M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8/7/60
22c. PHYSICIAN'S NAME (Type): Dr. C. James Duke, M.D.
22d. ADDRESS: 6607 Riverdale Road, Riverdale, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Aug. 9, 1960
23c. NAME OF CEMETERY OR CREMATORY: St. John
23d. LOCATION (City, town, or county) (State): Clinton, Md.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Hurtt Funeral Home, Waldorf Md
25a. REC'D BY REGISTRAR DATE: AUG 10 '60
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09528

9511 **CERTIFICATE OF DEATH**

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Laurel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundrel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Odenton
d. STREET ADDRESS: 211 Rita Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Laura — Middle: — Last: Wallace

4. DATE OF DEATH: Month: August — Day: 11 — Year: 19 60

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 26, 1882

9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): New Jersey

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William C. Green

14. MOTHER'S MAIDEN NAME: Prudence A. Simpkins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital Records
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO (b): Apoplexy — 6 days
DUE TO (c): Hypertension — 10 yrs

334X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chr - Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year: Hour o. m. p. m. 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/5, 19 60 to 8/11, 19 60, that I last saw the deceased alive on 8/11, 19 60, and that death occurred at 10:22 A. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: J M Warren M.D.
ADDRESS (Street, city or town, state):
DATE SIGNED:

PHYSICIAN'S NAME (Type): John M. Warren, M.D. 305 Prince George Street, Laurel, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug 15, 1960
22c. NAME OF CEMETERY OR CREMATORY: Cedar Grove Cem
22d. LOCATION (City, town, or county) (State): Gloucester City New Jersey

23. FUNERAL DIRECTOR'S SIGNATURE: DeWitt Donaldson
ADDRESS: Laurel, Md.

24a. RECEIVED BY REGISTRAR DATE: AUG 15 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9446

## CERTIFICATE OF DEATH

09529
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bladensburg
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 4910 - Taylor Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: Prince Geos
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bladensburg
d. STREET ADDRESS: 4910 Taylor St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: Thomas — Last: Ward

4. DATE OF DEATH: Month: Aug — Day: 13 — Year: 1960

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 27 Aug 1882

9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Westminister Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William Franklin Ward.

14. MOTHER'S MAIDEN NAME: Addie Missouri Hunter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: Claudia C. Ward — Address: Above,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive failure of senile myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 3 days.
DUE TO
(b): Left hemiplegia — 30 years
DUE TO
(c): generalized arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

334

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. / p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1955, 19__, to 13 Aug, 1960 that I last saw the deceased alive on 11 Aug, 1960, and that death occurred at 5 a. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas E Mattingly M.D. M.D. — ADDRESS (Street, city or town, state): 2200 Rhode Is. Ave. N.E. — DATE SIGNED:

PHYSICIAN'S NAME (Type): Thomas E. Mattingly, M.D. — Wash. 18, D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug 15-60
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
22d. LOCATION (City, town, or county) (State): Suitland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Simmons Bros. — ADDRESS: 1661-9d Hopkins PL SE Wash D C

24a. REC'D BY REGISTRAR DATE: AUG 15 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

FOR STATE HEALTH DEPT.

M

I

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9564

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09530

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1. **PLACE OF DEATH**
   a. COUNTY: Prince George — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Langley Park
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 1209 Ruatan St.

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Prince George
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Langley Park
   d. STREET ADDRESS: 1209 Ruatan St.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Earl — Middle: Faitt — Last: Waters

4. **DATE OF DEATH**: Month: Aug. — Day: 10, — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: January 26, 1920

9. AGE (In years last birthday): 40 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Technician

10b. KIND OF BUSINESS OR INDUSTRY: Dental

11. BIRTHPLACE (State or foreign country): Georgia

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Jesse Waters

14. MOTHER'S MAIDEN NAME: Self

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): WW II

16. SOCIAL SECURITY NO.: 578-24-2339

17. INFORMANT: Margaret Waters — Address: Same as # 2

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxia
DUE TO (b): Smothering
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

974X

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Secured a plastic bag over his head

20c. TIME OF INJURY: Hour: 4:00 XX p.m. — Month, Day, Year: 8/10 1960

20d. INJURY OCCURRED: While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) (County) (State): Langley Park P. G. Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

ACTUAL SIGNATURE: James I. Boyd M.D.

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): James I. Boyd

DATE SIGNED: 8/11/60

Address (Street, city, town, or county):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Aug. 16, 1960

22c. NAME OF CEMETERY OR CREMATORY: Arlington National

22d. LOCATION (City, town, or country) (State): Arlington, Virginia.

23. FUNERAL DIRECTOR: W. W. CHAMBERS CO., — ADDRESS: Riverdale, Md.

24a. REC'D BY REGISTRAR — DATE: AUG 15 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Krantz

M

I

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9565

## CERTIFICATE OF DEATH

Reg. Dist. No. 09531

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CAMP SPRINGS(RURAL)
c. LENGTH OF STAY IN 1b: 34 HOURS
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: USAF HOSPITAL ANDREWS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: DISTRICT OF COLUMBIA — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON DC
d. STREET ADDRESS: 3327-14th Place, SE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

47 X -3

3. NAME OF DECEASED (Type or print): First — Middle — Last: WEBB
4. DATE OF DEATH: Month AUGUST — Day 9 — Year 1960

5. SEX: MALE
6. COLOR OR RACE: CAUC
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9 AUG 1960
9. AGE (In years last birthday) yrs.
IF UNDER 1 YEAR: Months — Days 1
IF UNDER 24 HRS.: Hours 19 — Min. 00

10a. USUAL OCCUPATION (Give kind of work done during most af working life, even if retired): NA
10b. KIND OF BUSINESS OR INDUSTRY: NA
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WILLIAM M WEBB
14. MOTHER'S MAIDEN NAME: YUKO TAKEDA

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NA — (If yes, give war or dates of service): NA
16. SOCIAL SECURITY NO.: NONE
INFORMANT: RECORDS — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Atelectasis of Lungs
DUE TO
(b): Prematurity
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

762.5

INTERVAL BETWEEN ONSET AND DEATH
34 HOURS
34 Hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature af injury in Port I ar Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/7, 1960 to 8/8, 1960 that I last saw the deceased alive on 9/8, 1960, and that death occurred at 0455 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Arnold A Abrams M.D.
ADDRESS (Street, city or town, state): USAF HOSPITAL ANDREWS
DATE SIGNED: 9 August 1960

PHYSICIAN'S NAME (Type): ARNOLD A ABRAMS CAPT USAF MC
USAF HOSPITAL ANDREWS ANDREWS AFB WASH 25 DC

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 8-11-60
22c. NAME OF CEMETERY OR CREMATORY: D. C. Morgue
22d. LOCATION (City, town, or county) (State): Washington, D. C.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS
24a. REC'D BY REGISTRAR DATE AUG 12 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be mailed with the registror prior to buriol, cremotion, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

2050363XV2

1

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9504

09532

## CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1. PLACE OF DEATH
a. COUNTY: Price Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 22
d. STREET ADDRESS: 7368 Allenton Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Nina — Middle: Garfield — Last: Weese

4. DATE OF DEATH: Month: August — Day: 31 — Year: 19 60

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 2, 1882

9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Henry J. Lark

14. MOTHER'S MAIDEN NAME: Eliza Brewer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Wm. Twigg 7368 Allentown Rd. Washington

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Toxemia Secondary to
DUE TO (b): Generalized Pentonitis
DUE TO (c): Perforation of Recto sigmoid & Gangrene

570.5

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Intestinal obstruction

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug 29 1960, to Aug 31, 1960 that (I) (we) last saw the deceased alive on Aug 30, 1960 and that death occurred at 4, 15 AM from the causes and on the date stated above.

22a. SIGNATURE: William J. Rosson M.D. M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 8/31/60

22c. PHYSICIAN'S NAME (Type): W. D. Rosson, M.D.

22d. ADDRESS: 5304 Annapolis Rd Bladensburg, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept. 3, 1960

23c. NAME OF CEMETERY OR CREMATORY: Pinto Mennonite Cem.

23d. LOCATION (City, town, or county) (State): Pinto, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Charles L. George,

ADDRESS: Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: SEP 6 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Timus

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9505 — 09533 — Reg. Dist. No.

M

1. PLACE OF DEATH
a. COUNTY: Prince Geo — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: D/A
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Geo General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: Pr Geo
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X no fixed address
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

099

3. NAME OF DECEASED (Type or print): First CLAUDE — Middle — Last WELCH
4. DATE OF DEATH: Month 8 — Day 26 — Year 1960
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Mar 16 1913
9. AGE (In years last birthday): 47 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laboer
10b. KIND OF BUSINESS OR INDUSTRY: unemployed
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Bell welch
14. MOTHER'S MAIDEN NAME: Mary R. Medley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Address: Estelle welch Bowie md

1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | Toxemia | 1 day |
| DUE TO (b) | Generalized Peritonitis | 1 day |
| DUE TO (c) | Ruptured Duodenal ulcer | 1 day |

5410

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH: no
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): no
20c. TIME OF INJURY: Hour — o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

2

21. I certify that I taak charge of the remains described abave, held an Autapsy ☒, Inspectian ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Hamicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Dayton O Watkins M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED
EXAMINER'S NAME (Type): DAYTON O WATKINS

2

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/27/60
22c. NAME OF CEMETERY OR CREMATORY: Evergreen
22d. LOCATION (City, town, or county) (State): Bladensburg Md

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: F Gaeckle Sons Hyattsville Md
24a. REC'D BY REGISTRAR DATE: AUG 29 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9566

## CERTIFICATE OF DEATH

09535
Reg. Dist. No.

1. PLACE OF DEATH
o. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Camp Springs (RURAL)
c. LENGTH OF STAY IN 1b: 22 hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: USAF Hospital, Andrews AFB

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE: DISTRICT OF COLUMBIA
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON DC
47X-3
d. STREET ADDRESS: 2905 POMEROY RD SE
e. IS RESIDENCE ON A FARM? YES ☐ NO XX

050

3. NAME OF DECEASED (Type or print): First JENNIFER Middle ANNETTE Last Williams

4. DATE OF DEATH: Month August Day 5 Year 1960

5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4 August 1960
9. AGE (In years last birthday) yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours 22 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NA
10b. KIND OF BUSINESS OR INDUSTRY: NONE
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Earl L. Williams
14. MOTHER'S MAIDEN NAME: SHIRLEY L ELLIS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): NA
16. SOCIAL SECURITY NO.: NONE
INFORMANT: FROM RECORDS Address

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity
DUE TO (b): Atelectasis of lungs
DUE TO (c):
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

INTERVAL BETWEEN ONSET AND DEATH
(a) 22 hrs.
(b) 22 hrs

762.5

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8-4, 1960, to 8-4, 1960, that I last saw the deceased alive on 8-5, 1960, and that death occurred at 1205 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Louis E Potvin M.D.
ADDRESS (Street, city or town, state): USAF HOSPITAL ANDREWS
DATE SIGNED: 5 August 1960

PHYSICIAN'S NAME (Type): LOUIS E POTVIN USN MC
USAF HOSP ANDREWS ANDREWS AFB WASH 25 DC

| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Cremation | 8-5-60 | Morgue | Washington, D. C. |

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
24a. REC'D BY REGISTRAR DATE: AUG 9 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

215023 3XVO

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9567

# CERTIFICATE OF DEATH

09536

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CAMPT SPRINGS (RURAL)
c. LENGTH OF STAY IN 1b: 8 HRS
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: USAF HOSPITAL ANDREWS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: DISTRICT OF COLUMBIA — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON, DC
47X-3
d. STREET ADDRESS: 2905 POMEROY RD SE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: JOYCE — Middle: ELLEN — Last: WILLIAMS

4. DATE OF DEATH: Month: AUGUST — Day: 4 — Year: 1960

5. SEX: FEMALE

6. COLOR OR RACE: NEGROID

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4 AUGUST 1960

9. AGE (In years last birthday) yrs.
IF UNDER 1 YEAR: Months — Days: 8 — IF UNDER 24 HRS.: Hours — Min.: 10

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY: NA

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USAF

13. FATHER'S NAME: EARL L WILLIAMS

14. MOTHER'S MAIDEN NAME: SHIRLEY L ELLIS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NA
(If yes, give war or dates of service): NA

16. SOCIAL SECURITY NO.: NONE

INFORMANT: FATHER — Address: SAME AS #2

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): EXTREME PREMATURITY — INTERVAL BETWEEN ONSET AND DEATH: 8 HRS
762.5
Conditions, if ony, which gove rise to immediate couse (a), stoting the underlying couse lost.
DUE TO (b): ATELECTASIS — 8 HRS
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Doy, Year 19

20d. INJURY OCCURRED While ot work ☐ Not while ot work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 4 AUGUST, 19 60, to 4 AUGUST, 1960, that I last saw the deceased alive on 4 AUGUST 1960, and that death occurred at 1030A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Arnold A. Abramo M.D.
ADDRESS (Street, city or town, state): USAF HOSPITAL ANDREWS
DATE SIGNED: 4 AUGUST 1960

PHYSICIAN'S NAME (Type): ARNOLD A ABRAMO, CAPT USAF MC
USAF HOSP ANDREWS ANDREWS AFB WASH 25 DC

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 8-5-60
22c. NAME OF CEMETERY OR CREMATORY: Morgue
22d. LOCATION (City, town, or county) (State): Washington, D. C.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS

24a. REC'D BY REGISTRAR DATE: AUG 9 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

2250234XVO

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9440 **CERTIFICATE OF DEATH** Reg. Dist. No. 09537

1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville,
c. LENGTH OF STAY IN 1b 1 month
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hyattsville Convalescent & Rest Home
d. STREET ADDRESS 5002-54th Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Md.

3. NAME OF DECEASED (Type or print) First Emma Middle Anna Last Wittig
4. DATE OF DEATH Month 8 Day 10 Year 1960
5. SEX F
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 1-11-76
9. AGE (In years last birthday) 84 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Germany
12. CITIZEN OF WHAT COUNTRY? Germany ✓
13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) ----------
16. SOCIAL SECURITY NO.
INFORMANT Son Address Rudolph M. Wittig - 5002-54th Hyattsville

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | Dehydration & Malnutrition | 10 days |
| DUE TO (b) | Generalized Arteriosclerosis | many years |
| DUE TO (c) | ? Cancer Thyroid | ? |

450.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug. 1, 1960, to Aug. 10, 1960, that I last saw the deceased alive on Aug. 10, 1960, and that death occurred at 5 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Henry R. Wolfe M.D. ADDRESS (Street, city or town, state) 905 Sheridan St. Hyattsville DATE SIGNED 8/11/60

PHYSICIAN'S NAME (Type) Henry R Wolfe Hyattsville, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation
22b. DATE THEREOF 8/13/60
22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Crematory
22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS F. Gasch's Sons Hyattsville, Md.
24a. REC'D BY REGISTRAR DATE AUG 15 '60
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be [illegible] by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

09538

9523

1. PLACE OF DEATH
a. COUNTY Prince George MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale
c. LENGTH OF STAY IN 1b 18 days
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) heland Memorial Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Dale
d. STREET ADDRESS Box 104
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First William Middle h. Last Wood

4. DATE OF DEATH Month Aug. Day 20 Year 1960

5. SEX male

6. COLOR OR RACE white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH 6-4-88

9. AGE (In years last birthday) 71 yrs.

IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter

10b. KIND OF BUSINESS OR INDUSTRY Construction

11. BIRTHPLACE (State or foreign country) Md

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME John Wood

14. MOTHER'S MAIDEN NAME Emma R —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Hospital Record Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Prostate
DUE TO (b) Metastasis to Liver
DUE TO (c) & Brain

177X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7-18 19 to 8-20 19 60, that (I) (we) last saw the deceased alive on 8-20 19 60 and that death occurred at 5:06 P.M. from the causes and on the date stated above.

22a. SIGNATURE Oliver E Thompson M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS 901 Perrytown Dr. S. J. Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE THEREOF Aug 23, 1960

23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery

23d. LOCATION (City, town, or county) (State) Colmar Manor Md.

24. FUNERAL DIRECTOR'S SIGNATURE F Blasche Sons

ADDRESS Hyattsville Md

25a. RECD BY REGISTRAR DATE AUG 25 '60

25b. REGISTRAR'S SIGNATURE Clifton T. Perkins

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9568

## CERTIFICATE OF DEATH

09539
Reg. Dist. No.

1

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

| | |
|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY: PRINCE GEORGES<br>MARYLAND | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE: DISTRICT OF COLUMBIA<br>b. COUNTY: P. Geo. |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CAMP SPRINGS(RURAL)<br>c. LENGTH OF STAY IN 1b: 8 DAYS | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON DC 20 |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: USAF HOSPITAL ANDREWS | d. STREET ADDRESS: 3130 PARKWAY TERRACE DR<br>e. IS RESIDENCE ON A FARM? YES ☐ NO ☒ |

| 3. NAME OF DECEASED (Type or print) First | Middle | Last | 4. DATE OF DEATH Month | Day | Year |
|---|---|---|---|---|---|
| WILLIAM | E | WOODS | AUGUST | 22 | 1960 |

| 5. SEX | 6. COLOR OR RACE | 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | IF UNDER 1 YEAR Months / Days | IF UNDER 24 HRS. Hours / Min. |
|---|---|---|---|---|---|---|
| MALE | CAUCASIAN | | 18 NOVEMBER 1906 | 53 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| USAF | USAF | KANSAS | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| W S WOODS | MAUDE WELCH |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | INFORMANT | Address |
|---|---|---|---|
| YES | | MAZEL E WOODS | SAME AS #2 |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Myocardial infarction | 8 DAYS |
| DUE TO (b) | arteriosclerotic heart disease | 8 DAYS |
| DUE TO (c) | | |

420.0

Conditions, if ony, which gave rise to immediate couse (a), stoting the underlying couse lost.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

| 20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19 | 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
|---|---|---|---|
| | | | |

21. **I certify** that I attended the deceased from 14 AUGUST, 1960, to 22 AUGUST, 1960, that I last saw the deceased alive an 22 AUGUST, 1960, and that death accurred at 1:00 P M, from the causes and an the date stated abave.

ACTUAL SIGNATURE: [signature] M.D.

ADDRESS (Street, city or town, stote): USAF HOSP ANDREWS

DATE SIGNED: 22 AUGUST 1960

PHYSICIAN'S NAME (Type): ALBERT D CARILLI, CAPT USAF MC

USAF HOSP ANDREWS ANDREWS AFB WASH 25 DC

| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (Stote) |
|---|---|---|---|
| Burial | 26 Aug. 1960 | Mt. Hope Cemetery | Belleville, Illinois |

| 23. FUNERAL DIRECTOR'S SIGNATURE | ADDRESS | 24a. REC'D BY REGISTRAR DATE | 24b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Michael J. Rinaldi | Rinaldi Funeral Home, Inc. 816 H St., NE, Wash. 2, DC | AUG 26 '60 | [signature] |

Item 18 Film 271 9-16-60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9506

09540

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 10 Min
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: Prince George General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Bowie
d. STREET ADDRESS: Bowie Race Track Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Baby Boy; Middle: ; Last: Woodson

4. DATE OF DEATH: Month: Aug. Day: 19 Year: 1960

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 19, 1960

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months: ; Days: ; IF UNDER 24 HRS.: Hours: ; Min.: 10

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: William Woodson

14. MOTHER'S MAIDEN NAME: Mary Ellen Queen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mother — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Atelectasis
762.5
DUE TO
(b): Prematurity
DUE TO
(c):

Conditions, if any, which gove rise to immediate couse (a), stating the underlying couse last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug. 19, 1960 to Aug. 19, 1960, that (I) (we) last saw the deceased alive an Aug. 19, 1960 and that death occurred at 12:25 A.M. the causes and on the date stated abave.

22a. SIGNATURE: John Perkins M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Dr. John Perkins, M.D.

22d. ADDRESS: 5103 Hamilton St. Hyattsville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: 8--24--60

23c. NAME OF CEMETERY OR CREMATORY: Prince George's Gen. Hosp.

23d. LOCATION (City, town, or county) (State): Cheverly, MARYLAND

24. FUNERAL DIRECTOR'S SIGNATURE: Harry W. Penn, Jr.

ADDRESS: Harry W. Penn, Jr. Administrator

25a. REC'D BY REGISTRAR DATE: SEP 7 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

1000389XVO

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4) 15M 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9569 09541

1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chillum
c. LENGTH OF STAY IN 1b ?
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5810 Riggs Rd.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chillum
d. STREET ADDRESS 5810 Riggs Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Lillian Middle F. Last Young

4. DATE OF DEATH Month Aug Day 17 Year 1960

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 4/7/85
9. AGE (In years last birthday) 75 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Government Treasury Section Chief
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME J. Spencer Frazier
14. MOTHER'S MAIDEN NAME Minnie Morgan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. no
17. INFORMANT Helen I. Pudney Address 5810 Riggs Rd. Chillum, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

434.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Carcinoma (Primary) Right Breast with extensive Metastasis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3/25 1960 to 8/17 1960, that (I) (we) last saw the deceased alive on Aug 14 1960, and that death occurred at 11:45 AM, from the causes and on the date stated above.

22a. SIGNATURE D.X. Courtney M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED Aug 17-60
22c. PHYSICIAN'S NAME (Type) F.X. COURTNEY MD
22d. ADDRESS 3601 - 4th NW Wash DC

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 8/19/60
23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery
23d. LOCATION (City, town, or county) (State) Washington, D.C.

24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co
ADDRESS 2901 14th St. N.W. Washington 9, D.C.
25a. REC'D BY REGISTRAR DATE AUG 19 '60
25b. REGISTRAR'S SIGNATURE Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59